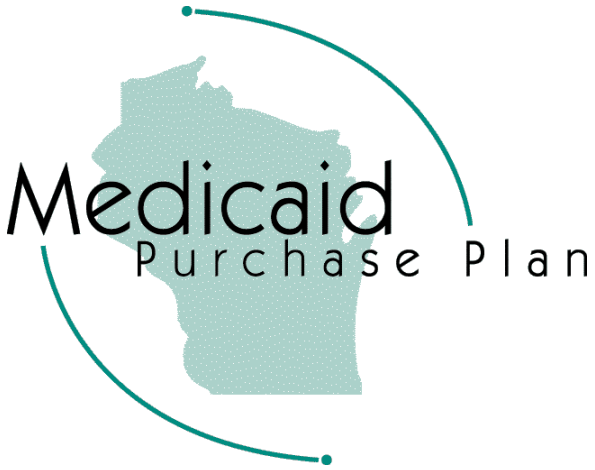
Medicaid Purchase Plan Evaluation
Annual Report



for

Center for Delivery Systems Development
and the Division of Health Care Financing
Department of Health and Family Services

January, 2005

Submitted by:
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Madison, Wisconsin

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I. Executive Summary

Under a contract with the Department of Health and Family Services (DHFS), Center for Delivery System Development (CDSD), APS Healthcare, Inc. is conducting an ongoing evaluation of the Medicaid Purchase Plan (MAPP). This annual report summarizes findings from year four of the evaluation, from January 2004 through December 2004.

Section 4733 of the Balanced Budget Act of 1997 (Public Law 105-33) allows states to make available a new Medicaid subprogram for individuals with disabilities whose family income is below 250% of the federal poverty level ($23,275 in 2004 for an individual). In Wisconsin, this subprogram is called MAPP. MAPP was created by 1999 Wisconsin Act 9 and was implemented on March 15, 2000. The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

The evaluation of MAPP conducted by APS began shortly after program implementation in 2000. The MAPP evaluation has three components: impact, fiscal and process. The previous MAPP Annual Reports emphasized the impact, fiscal and process evaluation components. This year's Annual Report is organized differently, focusing on analyses developed throughout 2004 to address specific questions regarding MAPP, or results of long-term analyses completed in 2004. Many of these analyses contribute significantly to MAPP policy discussions, while others provide a deeper understanding of the "on-the-ground" operation of the program.

Since the program's inception, MAPP enrollment has grown steadily. As of mid-November 2004, a total of 10,373 individuals had ever been enrolled in the program. Active enrollment through October, 2004 reached 7,327 individuals, an increase of 1,918 program participants over the same month in the prior year.

Over 51% of the participants are between the ages of 35 and 54. In general, the MAPP population consists evenly of men and women. In October 2004, MAPP participants had earned income ranging from $0 to $9,147 per month with an average of $230 and a median of $67[1] The 2004 figures represent a continued decline in average earnings from years one, two and three of the evaluation. MAPP participants averaged $393 per month in year one, $321per month in year two and $270 in year three.[2] The drop in average monthly income reflects the large number of new participants, most of whom enter MAPP with very low cash earnings from work.

[1] These figures include 7,335 participants with income information available through the CARES system. Earned income figures represent monthly earned income reported by participants through CARES as of October 2004.
[2] Year one earned income data came directly from the MAPP paper applications submitted by each county to CDSD and aggregated by APS.

MAPP participants whose gross individual income exceeds 150% of the federal poverty level (FPL), currently $13,965 for an individual, for their family size are subject to a premium. The majority of MAPP participants are not paying a premium to participate in MAPP. According to Medicaid eligibility data, the percentage of MAPP participants paying a premium has dropped almost 30% between October 2002 and October 2004, down to 9% of active MAPP participants from 13%. The percentage of premium payers has dropped over 35% since July 2002. The sum of all premiums collected in October 2004 was $102,649. From January 2002 through October 2004, MAPP premiums have generated almost $2.5 million. During the 2004 state fiscal year, premiums totaled $1,009,956.

Beginning in October 2003, the Wisconsin Division of Health Care Financing (DHCF) began considering modifications to the current premium formula to further off-set program costs. Initial discussions revolved around instituting a $25 minimum premium for all MAPP participants, irregardless of income, and increasing the amount of earned income used to determine the premium amount above the current 3%. DHCF conducted a very preliminary cost-savings analysis in October 2003. Based on the DHCF findings, APS Healthcare, Inc. was asked to develop a more robust estimate of cost savings for the state and to assess other possible changes to the MAPP premium determination, as well as modifications to the program's eligibility criteria.

The final estimates show that the greatest positive effect on the overall Medicaid budget would result from implementing a $25 minimum monthly premium for all participants who currently do not pay a premium, while maintaining the existing premium formula for those participants over 150% of FPL and not requiring evidence of FICA. This change would save Wisconsin Medicaid approximately $1,988,384 annually, while limiting the impact on MAPP enrollment. These and other MAPP policy changes were not implemented in 2004-2005, but may be revisited in the future.

In addition to the eligibility and premium change analyses conducted in 2004, APS conducted an analysis to determine the feasibility of creating a "MAPP Plus" initiative. The MAPP Plus concept was initially described in a paper prepared by the Department of Workforce Development (DWD) as a component of the Governor's initiative to "Grow Wisconsin" by investing in employees with disabilities. At the highest level, the goal of MAPP Plus is to increase access to health care insurance to employees with disabilities by removing the income limits and asset tests currently in place for MAPP. This alternative would create opportunities for individuals who otherwise qualify for Medicaid to work and earn more without risk of losing their health care coverage. The possibility of implementation is still being discussed at the state level.

In addition to the policy analyses discussed above, the MAPP Recipient Surveys and Disenrollment Survey were also completed in 2004. The Recipient Surveys point to a very low income working disabled population that needs some physical and emotional support to continue working or increase their work. MAPP participants are generally satisfied with the program, but feel that the current premium structure and lack of a thorough understanding of the policies and benefits associated with MAPP prevent them from taking full advantage of the program. The

Disenrollment Survey results point to other barriers that prohibit participants from continuing in the program. In addition to the two barriers discussed above, disenrollment findings suggest a general difficulty with obtaining, maintaining or increasing employment, as well as difficulty navigating the complex network of disability related benefits and eligibility criteria required for local, state and federal benefits, including MAPP.

The complexity of the Medicaid system is a barrier to providing an effective, efficient and equitable program for many people with disabilities. The complex array of public benefits can easily overwhelm consumers, particularly in the case of MAPP where there is evidence that some ES workers continue to be either not well informed about the program or exhibit apathy towards enrolling people into MAPP. As a result, several participants have either disenrolled from the program voluntarily or have been dropped from the program because they did not fulfill one or more of their eligibility requirements, often to their surprise.

If an applicant to the MAPP program is not currently employed, they can enter the Health and Employment Counseling (HEC) program to fulfill the employment eligibility requirement. HEC assists with the development of employment goals in the hope that the participant can leverage their new healthcare benefits to find employment within nine months (12 with an extension) to meet the employment requirement of the program.

In the first year of the MAPP evaluation it was discovered that a large number of MAPP participants reported $0 in earned income, but were not enrolled in the HEC program. The high number of $0 wage earners not enrolled in HEC raised concerns about the efficacy of the program. As this pattern persisted into the second and third years of the program, the Center for Delivery Systems Development (CDSD) in conjunction with APS Healthcare, Inc. were able to identify several program issues that were contributing to the low utilization of HEC. These issues included:

- HEC screeners had full-time duties with their employers and did not have a strong identification with the program.
- Many economic support (ES) workers used HEC screeners as substitute "MAPP staff" because they did not know who to contact with MAPP questions. This took time away from the screeners' HEC responsibilities and limited their effectiveness performing HEC screens.
- Insubstantial and ineffective marketing support for MAPP or HEC, and
- Limited outreach to the disability community

As a result of these early findings, CDSD took a number of steps to improve the effectiveness of HEC in 2002-2003. Although these steps succeeded at making HEC a more efficient and successful program, a large percentage of MAPP participants with $0 reported earned income still were not finding their way onto HEC. To further investigate the underutilization of HEC, CDSD tasked APS with interviewing each HEC screener on location in their counties and meeting with all HEC screeners at their June 2004 quarterly meeting to review any common issues/concerns from the individual interviews. APS conducted the interviews in the spring of 2004 and provided CDSD with a detailed report of the interview findings.

The problem with utilization is directly related to several structural barriers built into MAPP, most notably the acceptance of in-kind income to meet the work requirement; the lack of resources to conduct thorough verification of employment among program participants; and the lack of resources to provide vocational services as part of MAPP. Until these barriers are addressed it is likely that HEC will continue to be underutilized.

The MAPP evaluation also expanded into new analytic areas in 2004. APS addressed several CDSD research questions including the use of the Chronic Illness and Disability Payment System (CDPS) to group MAPP participants by chronic condition categories. Several other states with Medicaid buy-in programs have been struggling with determining their program participants' primary qualifying disabilities. Determining which group a program participant falls into, whether it be physically disabled, developmentally disabled or mentally ill would help researchers better understand where their buy-in programs are most effective and why. In an effort to determine these categorizations from a readily available data source such as each state's Medicaid management information system (MMIS), several states have turned to the CDPS or a home-grown variation of the tool. Despite its limitations, the CDPS does provide an indication of which chronic conditions are most prevalent among MAPP participants. State fiscal year analyses for 2003 and 2004 show that the most common chronic conditions among MAPP participants are psychiatric in nature, followed by cardiovascular, skeletal and nervous system related disorders.

The evaluation team also investigated age trends in the MAPP population, as well as examined tenure in MAPP and its impact on experiences with the program. Lastly, preliminary investigative work was done on the highest MAPP premium payers to determine the accuracy of their premium responsibilities, as well as factors that might contribute to their willingness to incur such a high out-of-pocket expense in order to maintain their healthcare coverage. As preliminary findings, these analyses may be revisited in 2005.

Based on the findings from year four of the MAPP evaluation, CDSD, in conjunction with APS, has developed a detailed list of 2005 activities and analyses to be conducted as part of the year five MAPP evaluation. These activities are designed to strengthen the findings presented in this report, but more importantly, to fill gaps where specific program and policy questions remain unanswered. The evaluators will examine the following topics.

- Further examine self-employment and in-kind income among MAPP consumers.
- Examine MAPP enrollee tenure, including a profile of the length of participation in the MAPP program.
- Conduct a cost comparison of enrollees using HIPP.
- Conduct analyses to examine the potential impact of Medicare Part D on the MAPP program and MAPP consumers.

II. Background

Section 4733 of the Balanced Budget Act of 1997 (Public Law 105-33) allows states to make available a new Medicaid subprogram for individuals with disabilities whose family income is below 250% of the federal poverty level ($23,275 in 2004 for an individual). In Wisconsin, this subprogram is called the Medicaid Purchase Plan (MAPP). MAPP was created by 1999 Wisconsin Act 9 and was implemented on March 15, 2000.

Evaluation Contract

Under a contract with the Department of Health and Family Services (DHFS), Center for Delivery System Development (CDSD), APS Healthcare, Inc. is conducting an ongoing evaluation of MAPP. This annual report summarizes findings from year four of the evaluation, from January 2004 through December 2004.

APS offers diversified health care consulting services, specializing in data analysis and reporting, program evaluation, survey administration and other technical health care services. MAPP evaluation surveys were administered in partnership with The Management Group (TMG). TMG is a management consulting and services organization with experience in health and long-term care.

Evaluation Components

The MAPP evaluation has three components: impact, fiscal and process. The impact evaluation examines the effects of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The fiscal evaluation monitors the effects of MAPP on state and federal Medicaid funding and examines the effects of MAPP on locally funded long-term care services. Finally, the process evaluation determines if the program is implemented equitably across the state and whether the program is efficient and effective. It also measures participant satisfaction through recipient and disenrollee surveys. The previous MAPP Annual Reports emphasized the impact, fiscal and process evaluation components. This year's Annual Report is organized differently, focusing on analyses developed throughout 2004 to address specific questions regarding MAPP, or results of long-term analyses completed in 2004. Many of these analyses contribute significantly to MAPP policy discussions, while others provide a deeper understanding of the "on-the-ground" operation of the program.

III. Program Overview

Program Goals

The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

Eligibility Criteria

In order to be eligible for MAPP, an individual must be a Wisconsin resident and at least 18 years old. They must be determined to be disabled by the DHFS Disability Determination Bureau (DDB). Participants must also be working or enrolled in a Health and Employment Counseling Program (HEC) and have countable assets under $15,000. Countable assets include items such as cash savings, life insurance policies, and stocks and bonds, but do not include an individual's home or vehicle.

Program Features

In addition to providing health care coverage, the MAPP program includes a number of features designed to foster independence.

Enrollment in the Health and Employment Counseling (HEC) program provides individuals an opportunity to enroll in MAPP to secure health care coverage, while seeking employment. Enrollment in the HEC program temporarily fulfills the MAPP work requirement by requiring development of an employment plan consisting of benefit counseling, employment barriers assessment, and a plan to address all identified barriers to employment. Upon approval of the employment plan, the MAPP work requirement is waived and the applicant becomes eligible for the MAPP program for at least nine months, with the opportunity for a three-month extension if necessary. If the enrollee remains unemployed after the three-month extension, he/she loses MAPP program eligibility. The HEC program is administered by Employment Resources, Inc. (ERI) under contract with the CDSD.

Once enrolled in MAPP, participants can establish Independence Accounts (IAs), which are intended to foster savings for items that increase personal and financial independence. By establishing an IA, MAPP participants can save earnings above the $15,000 countable asset limit for the program. Total annual deposits to IAs can not exceed 50% of gross earned income each year.

MAPP policies include a work exemption provision for individuals who are sick and need to take off of work for a period of time. Participants who have participated in MAPP for at least six months are eligible for the exemption. The exemption itself can last up to six months and is limited to two exemptions every three years.

Health Care Coverage

The MAPP program offers health care coverage to eligible individuals. Family coverage is not available. However, if more than one family member has a disability, each person with a disability may be eligible for the program if he/she meets all of the eligibility requirements.

MAPP participants are eligible for the same health care services available to any other group through Wisconsin's Medicaid program. These services are available at no cost to individuals whose total income is less than 150% of the federal poverty level (FPL). Individuals with a total income that meets or exceeds 150% of the FPL are required to pay a premium to participate in the program.

Premiums Requirements

Monthly premiums for MAPP are based on an individual's monthly income and family size. Spousal or other family member income is not counted in the premium calculation, but those individuals would be counted when determining family size. The amount of a MAPP recipient's premium is based on his/her adjusted earned and unearned income.

Unearned income includes Social Security benefits, disability benefits and pensions. Adjusted unearned income equals total unearned income less the following deductions:

- Standard living allowance ($667 per month for calendar year 2004)
- Impairment-related work expenses (IRWEs), such as transportation to employment
- Medical and remedial expenses (MREs), such as attendant care

Earned income is income from paid or self-employment. Adjusted earned income equals gross earned income before taxes and any remaining income deductions from one's unearned income. In other words, if one's unearned income is less than the sum of the allowable deductions, the difference can be applied as a deduction to one's earned income.

Premium income is the sum of one's adjusted unearned income and 3% of one's earned income. In the following example, the applicant receives an $850 monthly Social Security Disability Insurance (SSDI) payment and earns $1,200 per month. He spends $50 a month on cab fare to work and has $10 in medical payments per month.

Calculation of Monthly Premium

Monthly Unearned Income =	$ 850
Less Standard Living Allowance	*$ 667*
Less IRWEs	*$ 50*
Less MREs	*$ 10*
Adjusted Unearned Income	**$ 123**
Monthly Earned Income=	$1,200
Less Remaining Deductions	*$ 0*
Adjusted Earned Income	***$1,200***
	x .03
	$ 36
	+ 123
Premium Income	$ 159
Premium Amount[3]	$ 150

[3] Premium income between $150 and $175 results in a premium of $150. A premium Schedule is included as *Attachment A* in Section X Appendix.

IV. Program Demographics/Participant Characteristics

Enrollment Trends

Since the program's inception, MAPP enrollment has grown steadily. However, beginning with the automation of the MAPP application process in Client Assistance for Reemployment and Economic Support (CARES) in January 2002, the program has experienced significant growth. Total enrollment in July 2002 was 2,933 individuals, more than double the enrollment in July 2001. In the six months prior to automation, new enrollment averaged 82 individuals per month. In the six months after automation, 222 individuals were enrolled each month, on average. [4] Between August 2003 and July 2004, enrollment averaged over 248 individuals per month.[5] As of mid-November 2004, a total of 10,373 individuals had ever been enrolled in the program. Active enrollment through October, 2004 reached 7,327 individuals, an increase of 1,918 program participants over the same month in the prior year.

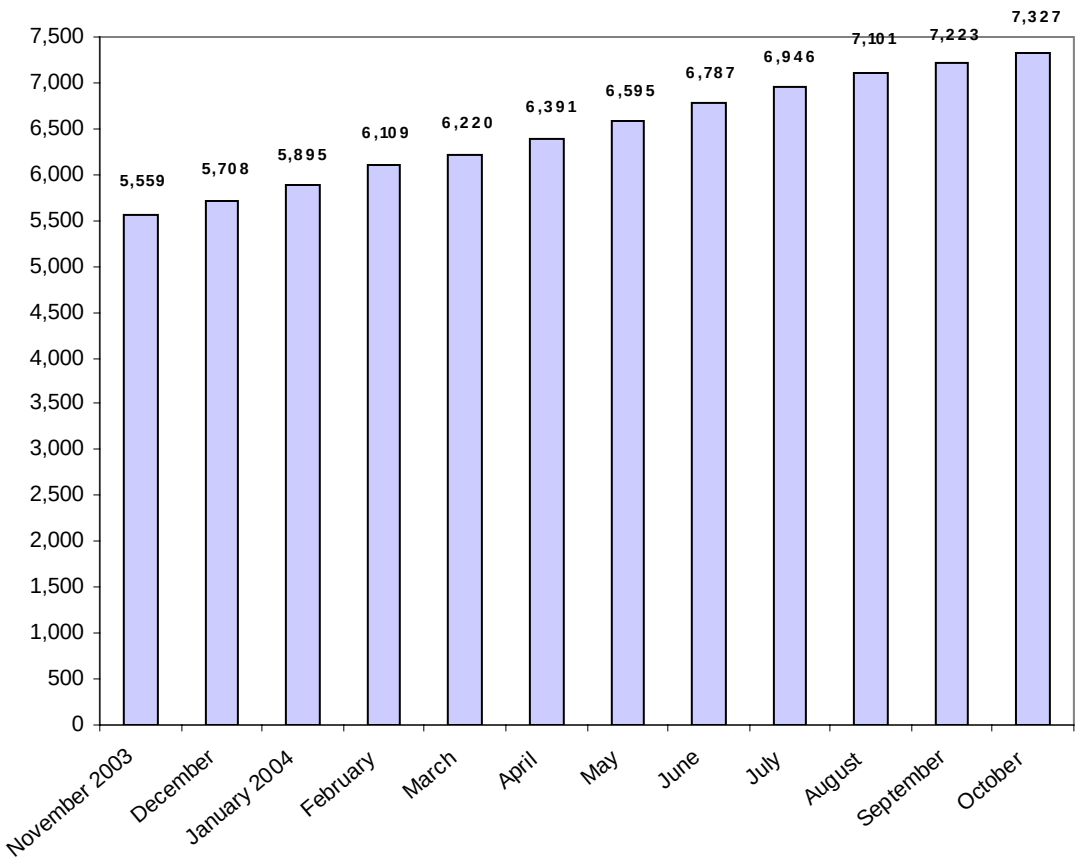
The growth in 2002 appeared to be a direct result of automation of the MAPP eligibility process in CARES. As noted in the first annual report and reiterated in the two following annual reports, the complexity of the manual enrollment process was seen by many county workers as a deterrent to enrollment. Consequently, it was expected that by making it easier for economic support (ES) workers to enroll individuals in MAPP through automation, MAPP enrollment would increase.

However, steady growth has continued to occur through 2003 and 2004, suggesting that something other than the automation of the enrollment process is at work. MAPP growth in 2003 and 2004 has coincided with an overall increase in Medicaid enrollment. Factors that might be contributing to the overall growth of Wisconsin Medicaid, and subsequently the MAPP program, may include a weak economy, lack of livable wage jobs or other socioeconomic factors.

Disenrollments from MAPP have also show a slight increase in 2004. The first seven months of 2004 averaged almost 112 disenrollments per month, whereas the final six months of 2003 averaged just about 90. While new enrollments continue to outpace disenrollments, the overall growth of the program has shown a slight slow down in recent months.

The continued growth of the MAPP population may also suggest the existence of a distinctively underserved disabled population in need of medical coverage to work. The chart on the following page summarizes enrollment from November 2003 through October 2004.[6]

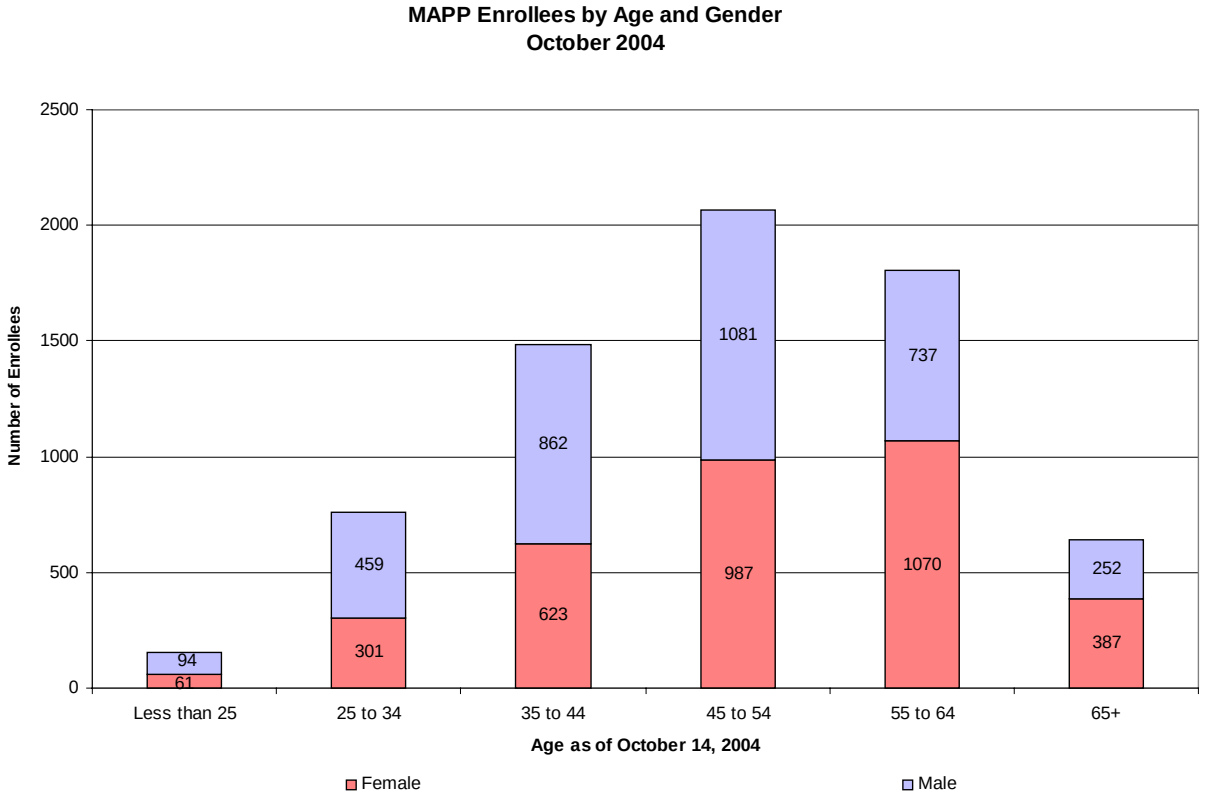
[4] Automation was implemented in mid January. The average includes January through June 2002.
[5] Data for this analysis was drawn from the most recent MAPP Quarterly Report completed in October 2004. Monthly enrollments and disenrollments are not reported for the three months prior to the Quarterly Report (including the month of the report) due to retroactive eligibility.
[6] The 2004 Annual Report has switched to a calendar year analysis. Most of the data used for this report was pulled in October and November 2004, and in turn, the most recent month with complete data is October 2004.



Please see *Attachments B, C and D* in Section X. Appendix for month by month summaries of enrollment, disenrollment and pre-and post-MAPP Medicaid eligibility periods.

Demographic Data

As of October 14, 2004, there were 6,914 individuals enrolled in MAPP. The chart on the following page provides a breakout of the population by age and gender.



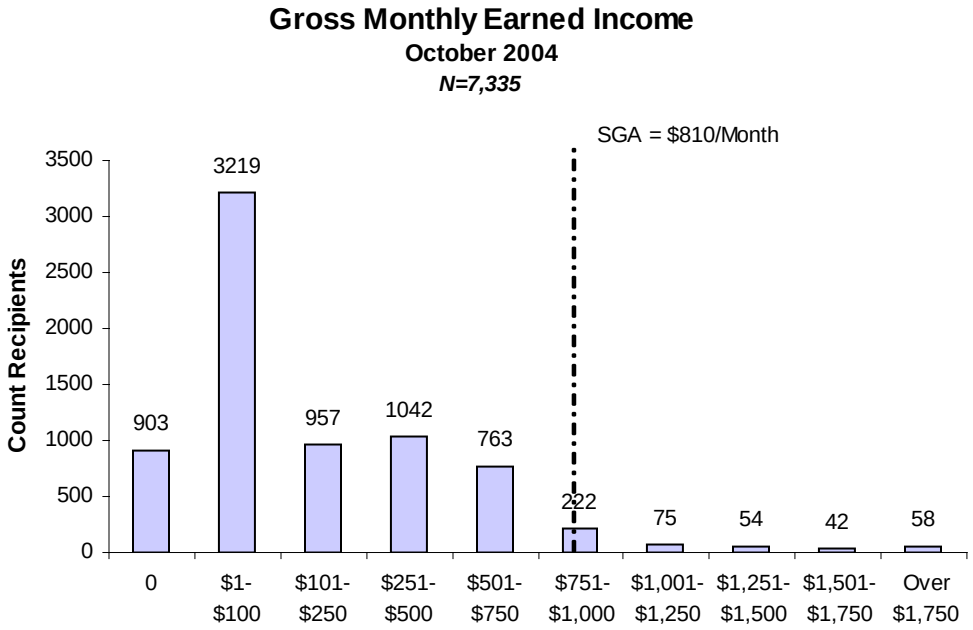
As the chart illustrates, over 51% of the participants are between the ages of 35 and 54. The MAPP population is split evenly between males and females. The proportion of men and women varies within each of the age categories, with the most disproportionate ratio occurring in the over 65 category, where 61% of the participants are female. Women represented 62% of the over 65 participants in year one, 68% in year two and 65% in year three.

In October 2004, MAPP participants had earned income ranging from $0 to $9,147 per month with an average of $230 and a median of $67.[7] The 2004 figures represent a continued decline in average earnings from years one, two and three of the evaluation. MAPP participants averaged $393 per month in year one, $321per month in year two and $270 in year three.[8] The drop in average monthly income reflects the large number of new participants, most of whom enter MAPP with very low cash earnings from work.

Average and median earned income in year four continue to be well below the substantial gainful activity (SGA) level of $810 per month used by the federal government to maintain social security disability eligibility. Disabled individuals earning above $810 per month risk losing their federal disability benefits[9], which may account for the large drop-off in wage earners above

[7] These figures include 7,335 participants with income information available through the CARES system. Earned income figures represent monthly earned income reported by participants through CARES as of October 2004.
[8] Year one earned income data came directly from the MAPP paper applications submitted by each county to CDSD and aggregated by APS.
[9] Individuals earning above $810 per month are only at risk of losing their Social Security Disability Income (SSDI) benefit.

the SGA level. The following chart shows the distribution of these participants by the amount of their monthy earned income.



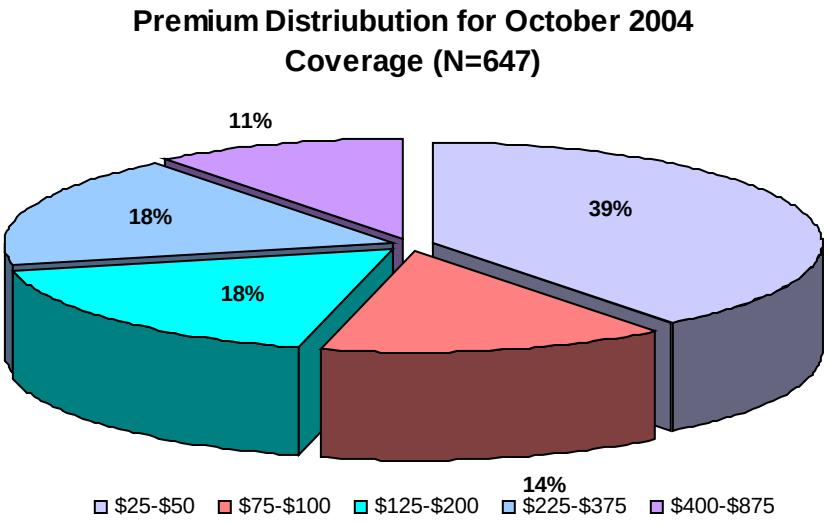
Source: CARES October 2004

Premium Status

MAPP participants whose gross individual income exceeds 150% of the federal poverty level (FPL)[10] for their family size are subject to a premium. The majority of MAPP participants are not paying a premium to participate in MAPP. According to Medicaid eligibility data, the percentage of MAPP participants paying a premium has dropped almost 30% between October 2002 and October 2004, down to 9% of active MAPP participants from 13%. The percentage of premium payers has dropped over 35% since July 2002. *Attachment E* in Section X. Appendix provides a monthly summary of MAPP enrollment by premium status.

For the October 2004 benefit month, MAPP premiums ranged from $25 (the minimum possible premium amount) to $1,174.[11] Of the 647 individuals paying premiums for October coverage, just over 39% were paying either a $25 or $50 premium[12]. Another 14% were paying a $75 or $100 premium and 18% were paying between $125 and $200. The remaining 28% pay premiums in excess of $200 per month. The average premium collected was $161.91. The average premium amount has increased almost $20 since January 2002. Based on the existing premium formula, which weighs unearned income more heavily than earned income, the continuing decrease in earned income, in conjunction with the increase in the average premium payment suggests the possibility of increased SSDI among MAPP participants. See the graph on the following page for a summary of premium amounts owed for October 2004.

[10] The current FPL for an individual is $13,965 annually.
[11] If the sum of Adjusted Countable Unearned Income and Adjusted Earned Income is greater than $1,000.00 per month, the premium shall be equal to the exact dollar amount of this sum.
[12] The premium schedule is set at increments of $25.



The sum of all premiums collected in October 2004 was $102,649. From January 2002 through October 2004, MAPP premiums have generated almost $2.5 million. During the 2004 state fiscal year, premiums totaled $1,009,956.

Medicaid and MAPP

The vast majority of MAPP participants were Medicaid eligible prior to their enrollment in MAPP. Of the 9,449 individuals who were eligible for MAPP between January 2000[13] and July 2004, 64% were enrolled in Medicaid in the month prior to their MAPP enrollment. Over 8,100 (86%) were enrolled in Medicaid at some point in time prior to their MAPP enrollment. Eighty-four percent of the MAPP participants eligible in October 2004 also had Medicare coverage. From the program's inception through July 2004, 2,516 individuals have disenrolled from MAPP at least once. The majority of the individuals who disenroll from the program subsequently re-enroll in non-MAPP Medicaid. Almost 99%, or 2,485, of program participants with at least one disenrollment had at least one post-MAPP Medicaid eligibility segment.[14] The majority of the post-MAPP Medicaid eligibility segments were under SSI-related eligibility criteria.

MRE and IRWEs

MAPP participants are allowed to deduct Impairment Related Work Expenses (IRWEs) from their income for the purposes of calculating financial eligibility and premium amounts for MAPP and are able to deduct Medical & Remedial Expenses (MREs) for the purpose of calculating premiums amounts. Information on MREs and IRWEs is collected by ES Workers as part of the MAPP application process. Detailed lists of IRWEs and MREs can be found in *Attachment F:* IRWEs and MRE Examples in Section X.

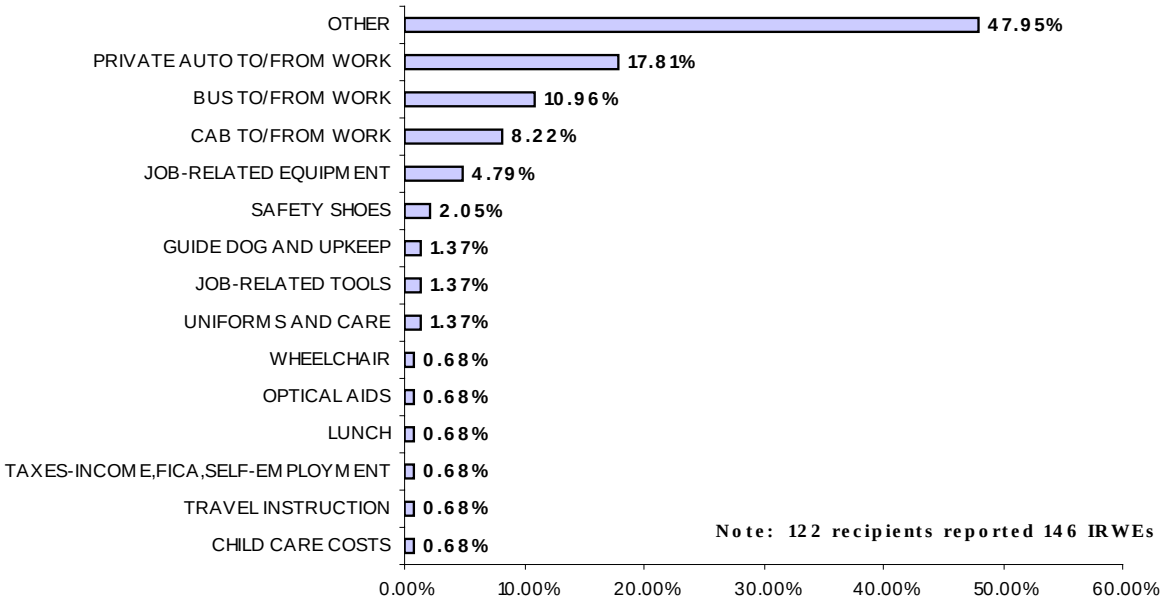
[13] While MAPP began in March of 2000, there were a number of individuals who had their initial eligibility backdated to January 2000. Under Medicaid policy, eligibility can be backdated three months from application if the individual would have met all eligibility criteria for those months.

[14] Please note that an individual may have more than one disenrollment and more than one post-MAPP eligibility segment. For example, as a result of changing income, a participant could have disenrolled from MAPP in February 2001; been on SSI-related Medicaid in March and April; re-enrolled in MAPP for May and June; disenrolled from MAPP and became eligible for non-MAPP Medicaid a second time.

Consistent with prior years, it appears that very few participants report MRE or IRWE expenses in 2004. October 2004 CARES data indicate that only 122 of 7,335 (1.7%) MAPP participants report IRWE expenses. This is down for a third consecutive year. The minimum expense identified was $2.25 and the maximum was $1,359. The average IRWE expense across all IRWE types rose in the first three years of the program. The year three average was $42 over year two and almost $100 over year one; however, the 2004 data show an average expense that is almost $115 less than 2003. The average IRWE expense in 2004 was $142. It is possible that the lower than expected utilization of IRWEs and the reduced average from 2003 reflects poor data quality rather than an underutilization of this benefit.

Transportation expenses accounted for 37% of all IRWE expenses. The following chart categorizes the 146 reported expenses, representing 122 participants, by category as reported in CARES. The frequent use of the "other" category somewhat limits our ability to assess the needs of MAPP participants in terms of work-related supports.

Distribution of Impairment Related Work Expenses (IRWEs) by Type of Expense



Over 5% of the participants identified MRE expenses in October 2004. Just over 6% of applicants identified MRE expenses in 2003, with just under 10% in 2002. The average MRE expense has dropped from $179.70 in 2002 and 2003 to $154.69[15] in 2004. The minimum expense was less than $1 and the maximum expense was $8,844, the same as in 2003. This finding suggests MREs may also not be updated regularly. Also, ES workers enter data into CARES as "out of pocket medical/remedial;" therefore, there is no way of identifying the types of expenses incurred by MAPP participants.

[15] This figure represents an average MRE expense per person who reported MRE expenses. 395 MAPP participants reported 424 MREs.

County ES workers have had four years to become familiar with this benefit, yet IRWE use has remained minimal. MREs are used throughout the Medicaid system for other sub-programs and should be familiar to most county workers. Over the past two years, it was hoped that ES workers would begin taking advantage of the 38 MRE codes available to describe MREs in order to provide more detailed information regarding these types of expenses. Unfortunately, the use of the other MRE codes has not yet occurred. The data suggest that reporting IRWEs and MREs at the county level needs further investigation to determine if the reporting process is flawed, or if participants are truly not taking advantage of these benefits. Additional training on the use of IRWEs and MREs may also be helpful to increase awareness and identification of these expenses among county workers.

Health Insurance Premium Payment (HIPP)

Under HIPP, Medicaid pays the "employee share" of the participant's or the participant's spouse's employer sponsored health insurance premium if it is cost-effective, thus reducing Medicaid expenditures. This benefit became available to MAPP participants in October 2001.

As of October 2004, 61 MAPP participants were participating in the HIPP program. Employers ranged from county governments and school districts, to regional electric cooperative and large private employers. These employers cover retail, manufacturing, banking and customer service. HIPP has grown slowly since it first became available in 2001. From October 2001 to October 2002, MAPP HIPP participation grew from 7 to 21 participants and increased another 18 participants as of October 2003. Just over 90 MAPP participants have participated in HIPP at some point during their time in MAPP.

Although HIPP enrollment continues to increase, the relatively small number of HIPP participants suggests that either employer sponsored health insurance is not available to most MAPP participants, HIPP is not cost-effective for most participants, or county workers are not familiar with the benefit. A comprehensive cost-effectiveness analysis of MAPP HIPP participants is scheduled for 2005. This analysis will investigate the cost-effectiveness of HIPP for MAPP enrollees and illuminate any barriers to enrollment and utilization of HIPP among MAPP participants.

V. Policy Considerations

Budget Impact of Proposed Eligibility and Premium Changes

The MAPP program has a built-in cost-sharing mechanism to reduce the expense to the state of providing Medicaid coverage to working adults who may otherwise not qualify for this coverage. MAPP collects premiums from program participants to off-set some of the program's costs. The premium amounts collected as part of MAPP are dependent upon the participant's monthly earned and unearned income, and family size. Currently, any program participant with individual gross monthly earned and unearned income below 150% of the FPL based on their family size (currently $13,965 for a family of one), is not required to pay a premium. When determining whether someone is liable to pay a premium, no disregards are taken from the individual's monthly earned and unearned income.

If the individual's income is above 150% of the FPL for their family size, a premium calculation formula kicks in to determine the amount of the individual's premium liability. The individual's monthly unearned income is adjusted using the standard living allowance (currently $667)[16], any monthly Independence Related Work Expenses (IRWEs) and any monthly Medical/Remedial Expenses (MREs). At this point in the premium formula, the individual's monthly earned income is reduced by any other deductions that the participant may qualify for, or if their adjusted monthly unearned income is less than zero, this amount is subtracted from their monthly earned income, as well. The final premium liability is determined by adding the adjusted monthly unearned income, if greater than zero, to 3% of the adjusted monthly earned income figure. The small percentage of monthly earned income used in the final premium calculation is done to encourage work and minimize any penalty on increasing wages. Lastly, the gross premium liability is placed within a series of rate bands ranging from $0 to $1,000 in $25 increments. Anyone with a premium liability below $25 currently does not pay a premium, and all premiums over $1,000 are calculated as the exact dollar amount from the premium calculation formula.

Beginning in October 2003, the Wisconsin Division of Health Care Financing (DHCF) began considering modifications to the current premium formula to further off-set program costs. Initial discussions revolved around instituting a $25 minimum premium for all MAPP participants, irregardless of income, and increasing the amount of earned income used to determine the premium amount above the current 3%. DHCF conducted a very preliminary cost-savings analysis in October 2003, followed by extensive discussion within CDSD regarding the most appropriate changes to make to the premium formula, if any. The DHCF proposal would have required a statutory change, with implementation occurring no earlier than July 1st, 2004.

Based on the DHCF findings, APS Healthcare, Inc. was asked to develop a more robust estimate of cost savings for the state and to assess other possible changes to the MAPP premium determination, as well as modifications to the program's eligibility criteria. The original estimates considered the impact of several changes to both the basic program eligibility requirements, as well as changes to the existing premium structure. These considerations included:

[16] The MAPP Standard Living Allowance (SLA) equals federal SSI plus state SSI supplement plus $20.

1. Requiring evidence of any Federal Insurance Contribution's Act (FICA) contributions, such as wage stubs or self employment tax forms in order to qualify for MAPP.
2. Requiring evidence of a minimum monthly FICA contribution of $296.67[17], as opposed to ANY FICA as in item one.
3. Implementing a $25 minimum premium for all program participants.
4. Implementing a $25 minimum premium for all program participants with individual income above 150% of FPL for their family size.
5. Combining items one and three, resulting in any FICA contributions with all program participants paying a minimum $25 premium.
6. Combining items one and four, resulting in any FICA contributions with only those program participants with income above 150% FPL paying at least a minimum $25 premium.
7. Combining items two and three, resulting in FICA contributions above $296.67 with all program participants paying a minimum $25 premium.
8. Combining items two and four, resulting in FICA contributions above $296.67 with only those program participants with income above 150% FPL paying at least a minimum $25 premium.

These estimates required several assumptions, including the number of non-premium paying program participants who are likely to leave MAPP due to the $25 minimum premium, both among all participants below 150% FPL and among those with income greater than 150% of FPL, as well as the number of individuals who leave MAPP only to re-enroll in another Medicaid eligibility category. The effect of the FICA changes was calculated using actual participant income data. Two options were considered. The first used any countable earned income as evidence of FICA contributions. The second required monthly earned income above $296.67 as proof of FICA contributions.

Based on disenrollment data available through preliminary Disenrollment Survey results and past literature on the topic[18], it was assumed that 5% of the current non-premium payers would permanently leave MAPP if they were required to pay a $25 premium. Also, based on previous experience with MAPP participants switching to other Medicaid eligibility categories, it was assumed that 94% of those who leave MAPP either due to the FICA changes or the $25 minimum premium change, would re-enroll in another Medicaid category, leaving only 6% of these groups without subsequent Medicaid coverage.

These estimates were circulated among CDSD and DHCF staff for discussion, questions and revisions in early 2004. During these discussions, a third major change to the MAPP eligibility and premium requirements was suggested. CDSD requested impact estimates for removing the $25 dollar rate bands used to calculate the final premium amounts. Removing the rate bands would result in participants paying the exact amount of their premium calculation, as opposed to rounding down to the nearest $25 increment.

[17] $296.67/month is the equivalent of $890 per quarter, which represents the Social Security Administration's (SSA) definition of a qualifying quarter for Social Security Disability Insurance (SSDI).
[18] Source: "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-income Populations." Julie Hudman and Molly O'Malley. The Kaiser Commission on Medicaid and the Uninsured.

Following detailed discussions with CDSD, the Bureau of Health Care Eligibility (BHCE) within the DHCF drafted a discussion paper recommending a change to the MAPP eligibility criteria that would require proof of FICA contributions from any wages. It is the State's understanding that this change could be implemented without statutory changes and without CMS approval. Requiring the SSA SSDI insured status amount of $296.67 per month was dismissed, as it would require approval from CMS.

Following these recommendations, the DHCF requested updated estimates from CDSD via APS using state fiscal year (SFY) 2004 data. Due to claims lag[19], it was determined that the 12-month period ending March 31, 2004 would be used instead. Previous assumptions were also modified based on feedback from CDSD and the DHCF.

Average per-member per-month expenditures were calculated using total MAPP expenditures during the 12-month period April 2003 through March 2004 ($43,536,150) divided by the total number of MAPP participants (7,334) with ANY eligibility during that time period. This method was chosen to account for any participants who leave MAPP for some period of time and then re-enter the program within the 12-month window. As a result, this method accounts for disenrollments and re-enrollments, and provides a more accurate average annual expenditure per MAPP participant when used to calculate annual savings based on the proposed eligibility and premium changes.

A major concern raised during discussions of the proposed MAPP eligibility and premium changes was the impact on enrollment of introducing a FICA requirement to the program. MAPP is a work incentive program where many program participants find employment that either pays very little, is sporadic, or is paid in-kind. Based on experience with the program and its participants, very little of this income is formally reported, which would significantly limit the participant's ability to show evidence of FICA contributions. As a result, it is feared that a significant number of current MAPP participants would no longer be eligible for the program. This change would also have an adverse financial impact on MAPP, as well as the overall state Medicaid budget. The administration and evaluation of the MAPP program is funded in part by a Medicaid Infrastructure Grant (MIG), for which funding eligibility is based on a percentage of the total claims paid for program participants.[20] Any proposed FICA change could significantly reduce the number of people served by Wisconsin MAPP, yet only reduce overall Medicaid expenditures slightly or possibly remain at their current levels due to re-entry through other means. Any reduction in program enrollment would most likely result in decreased MIG funding.

To address this concern, a third FICA estimate was developed. The original two estimates either counted any FICA contribution, reducing MAPP enrollment by an expected 13%, or counted any FICA contribution over $296.67 per month (the SSA insured status level), reducing MAPP

[19] Claims lag refers to the time necessary for all Medicaid claims to be accurately processed, investigated if necessary, and reconciled to produce accurate claims data files to be used for analysis. This process usually takes approximately three months, but may take up to six months in some rare cases.

[20] The MIG grant provides funding up to a maximum of 10% of the MAPP participants' claims annually.

enrollment by an expected 71%[21]. The third FICA alternative used the point at which any working individual is required to begin paying FICA. These amounts are $1,400 per year or $117 per month for an employed person, and $433 per year or $36 per month for the self-employed.[22] Based on this third FICA estimate, it was estimated that MAPP enrollment would be reduced by approximately 52%. This alternative has been accepted as the most accurate estimation of the effect of requiring evidence of FICA on MAPP participation levels; however, given the nature of the program as a work incentive for people with disabilities and the difficulty with obtaining the necessary FICA records, it is believed that this third model may also underestimate the reduction in MAPP participation.

Final estimates also assumed that 86% of the people who leave MAPP due to the eligibility and premium changes would re-enroll in some other Medicaid eligibility category, as opposed to the original 94% estimate. This estimate was revised based on experience with previous Medicaid eligibility. Approximately 64% of all MAPP participants have been enrolled in Medicaid in the month prior to their MAPP eligibility, and 86% have had prior Medicaid coverage at some point before participating in MAPP. Therefore, it is likely that between 64% and 94% of MAPP participants who leave the program will return to Medicaid, hence the middle figure was chosen for the final estimates.

The final estimates show that the greatest positive effect on the overall Medicaid budget would result from implementing the $25 minimum monthly premium for all participants who currently do not pay a premium, while maintaining the existing premium formula for those participants over 150% of FPL. This change would save Wisconsin Medicaid approximately $1,988,384 annually, while having the smallest impact on MAPP enrollment and the accompanying MIG funding eligibility. The $25 minimum premium requirement would require a statutory change; therefore, if accepted, the change could not be implemented until sometime in 2005. Although the FICA changes would not require a statutory change, these changes have been postponed until they can be analyzed further. Modifications to the premium formula, such as changing the earned income "tax" from 3% to 5%, or removing the rate bands are still being considered and may be reevaluated in 2005, as well. The final estimates can be found in Section X. Appendix as *Attachment G.*

MAPP Plus

In addition to the eligibility and premium policy changes discussed during 2004, CDSD also asked APS to conduct an analysis to determine the feasibility of creating a "MAPP Plus" initiative. The MAPP Plus concept was initially described in a paper prepared by the Department of Workforce Development (DWD) as a component of the Governor's initiative to "Grow Wisconsin" by investing in employees with disabilities. At the highest level, the goal of MAPP Plus is to increase access to health care insurance to employees with disabilities by removing the income limits and asset tests currently in place for MAPP. As discussed earlier, MAPP eligibility is currently limited to individuals with countable income below 250% of the federal poverty level (FPL) and countable assets of less than $15,000. Countable income at 250% of the

[21] The original estimates showed a reduction in MAPP participants of 68%, versus the 71% from the updated estimates in July 2004.

[22] CARES provides self-employment data allowing the two earnings levels to be applied accurately across all MAPP participants with records provided by CARES.

FPL is approximately $47,000 for a single person. Additional deductions for qualified medical and independence expenses would allow individuals with higher incomes to qualify for the program.

In June 2004, representatives from CDSD, DWD and APS met to discuss possible paradigms for the MAPP Plus concept. The group quickly agreed that there were a number of possibilities for designing a program to achieve the goals of MAPP Plus and that each option would have pros and cons in terms of costs, administrative feasibility, state and federal approval and appeal to employees with disabilities and their employers. After a lengthy discussion, it was decided that APS would conduct a feasibility analysis of a hypothetical program with the following characteristics:

- Individual coverage would be available to individuals engaged in full-time employment who are currently eligible for MAPP.
- The income test for earned or unearned income and the asset test would be removed.
- Market-rate premiums that would achieve budget neutrality for the program and allow individuals or employers to pay the premium would be established.

It was agreed that the first step in this analysis would be an informational meeting with DHFS, Bureau of Health Care Eligibility (BHCE) staff to gain a better understanding of the potential federal Medicaid barriers to MAPP Plus program development. This meeting was held on July 7, 2004. In preparation for this meeting, APS developed a number of questions to guide the discussion. A listing of these questions is provided in the Section X. Appendix as *Attachment H.*

The ability to make MAPP Plus cost neutral through premiums was identified as one of the most significant barriers to the creation of a MAPP Plus program as defined by the June 16th work group for a number of reasons:

- The number of individuals who would be eligible for MAPP Plus and would choose to enroll in the program is expected to be relatively small. In June, only 471 (representing 279 households) of the 6,667 MAPP enrollees had income above 200% of the FPL. The average annual Medicaid expenditure for these individuals was approximately $7,200 from April 2003 through March 2004. Less than one-third had above average costs and would be likely to pay a premium based on average benefit cost plus administrative costs. Some of these individuals would also need to increase their earnings by as much as 25% before they would be ineligible for MAPP. Therefore, it is expected that only a small subset of the 471 individuals would choose to graduate into MAPP Plus. The small number of program participants, many with significant health care needs, would make it difficult to predict health care utilization and associated costs. For example, a single high-cost health care service (e.g. major surgery with complications) could easily push program costs beyond premium revenues.

  A recent Milwaukee Business Journal article documented the difficulty the Partnership[23]

[23] The Wisconsin Partnership Program (WPP) coordinates acute, primary and long-term care services funded by Medicare and Medicaid at several community-based organizations throughout the state. WPP is intended to improve health care delivery by removing some of the inefficiencies of the current health care delivery system by

programs have had in managing medical costs for the elderly and disabled within the capitation payment amounts received from the State. Kirby Shoaf, Executive Director of Community Care, states that a small number of major medical bills can significantly impact the bottom line. He further state, "You need to have huge enrollment numbers so that the 'rule of large numbers' works. We have 860, and that doesn't always work. We have some months when we lose money."

- Establishing premiums at a level intended to cover total program expenditures for individuals with significant health care needs is akin to creating a high risk health insurance pool. Such a program would be vulnerable to many of the challenges faced by these pools across the country such as adverse selection. In other words, individuals who are likely to pay premiums that cover 100% of average expected costs are likely to be individuals who expect to have health care expenditures in excess of the premiums, otherwise there would be no benefit (i.e., insurance) to program participation.

  Over time, this could result in a situation where program participation is limited to individuals with very, very high costs, which would exacerbate the situation and lead to the so called "death spiral" experienced by the Wisconsin Health Insurance Risk Sharing Pool (HIRSP) in the 1990's. During that period, HIRSP enrollment was declining while program costs were increasing leading to quickly rising premiums, which lead to further declines in enrollment. The individuals who remained on the plan had relatively high costs, which led to higher premiums, which led to further reductions in enrollment. The end result was a severe financial crisis where the plan ran out of funding and claims were not paid for over four months. To keep the plan afloat, an additional $2 million was collected from insurers through an emergency assessment.[24]

- Even with sufficient data and the expertise of actuaries, it would be nearly impossible to accurately predict total health care expenditures of any size group. As a result, the only option for creating a program that is truly budget neutral would be to recover the difference between premium revenues and program expenditures for a given year through increased premiums in the following year. Such a policy would likely accelerate the adverse selection problem identified above as individuals would be paying more than 100% of the average expected cost.

For these reasons, alternative program structures were explored during the July 7th meeting. The group ultimately decided that the most effective means of achieving the goal of MAPP Plus would be to create a new Medicaid eligibility category under MAPP. Individuals with at least six consecutive months of prior Medicaid eligibility would be allowed to "graduate" into MAPP

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coordinating benefits and providing services through a central location which allows people to remain in their communities while still controlling costs.

[24] In order to maintain the long-term viability of HIRSP, a significant restructuring of the plan's funding mechanism was undertaken in the late 1990s, and subsequently state general purpose revenue (GPR) was appropriated to help fund the plan. In 2002-03, after deducting the $9.5 million GPR subsidy from total plan costs, 60% of the plan costs were funded through premium revenues. The remaining costs were covered through insurer assessments and provider contributions. Premium and deductible subsidies are also funded by insurer assessments and provider contributions.

Plus as they achieved higher levels of income.[25] BHCE confirmed that current federal Medicaid regulations would allow Wisconsin to establish a Medicaid eligibility category with no income test; however, this change would require a federal CMS waiver to allow MAPP applicants to be treated differently from MAPP participants.

This MAPP Plus option is not expected to result in additional benefit costs to the State as eligible individuals would have already been receiving Medicaid benefits[26] and would have likely maintained their Medicaid eligibility in the absence of this program. In fact, very few individuals leave MAPP due to earnings that exceed the income cap. Approximately 94% of individuals who leave MAPP subsequently enroll in Medicaid through alternative eligibility criteria with lower income limits. Of the 6% who do not subsequently enroll in Medicaid, it is expected that the vast majority left the program for reasons other than increased earnings based on data obtained through a MAPP disenrollment survey. According to the survey, only 15% of disenrollments for reasons other than death are in any way related to increased earnings or assets.

Under this alternative, HIPP would be mandatory for MAPP Plus participants. In other words, MAPP Plus participants would be required to enroll in the employer-sponsored insurance and Medicaid would cover eligible services and costs not covered by the employer sponsored plan. This aspect of the program would serve to control Medicaid benefit costs as Medicaid would wrap around the coverage available through the employer and participants would have access to the same services and benefits as other Medicaid eligibles.

All MAPP Plus participants would be required to pay a premium to participate in the program. The premium calculation would be identical to the MAPP premium calculation, which is based on an individual's earned and unearned income. Consequently, due to higher income, premiums would be higher for MAPP Plus participants than MAPP participants, but in most instances would not cover 100% of that individual's benefit costs.

The current asset test of $15,000 would be maintained in order to limit the opportunity for individuals with high assets and low income to divest for six months as a means of obtaining Medicaid eligibility. Lastly, the independence account available under MAPP would be available under MAPP Plus. MAPP participants can deposit up to 50% of their annual earnings in registered independence accounts. These deposits are then exempt from the $15,000 asset test.

To conclude, it appears that a cost effective and administratively feasible mechanism for increasing access to health care insurance for employees with disabilities is to remove the income limits currently in place for MAPP. This would increase access to Medicaid for individuals who earn more (or have the potential to earn more) than the current income limit for

[25] This is similar in concept to the BadgerCare eligibility criteria, which allows families with income below 185% of the federal poverty level (FPL) to enroll in the program. Once enrolled in BadgerCare, families can earn up to 200% of the FPL before becoming ineligible. BadgerCare has a federal CMS waiver in place to allow applicants to be treated differently than participants.

[26] The group acknowledged that it would be possible for an individual who currently exceeds the Medicaid income limit to intentionally lower their income for six months in order to qualify for Medicaid and subsequently graduate into MAPP Plus. However, this was not expected to occur in many situations because these individuals have likely found alternative means for meeting their health care needs in the absence of MAPP Plus.

the program. As stated above, the original concept for creating a self-funded program would essentially create a new, high-risk insurance program. The difficulty in estimating total program costs given the small size of the eligible population and the historical experience of HIRSP highlights some of the key difficulties such a program would encounter.

Alternatively, creating a new Medicaid eligibility category, which limits access to MAPP Plus to individuals with six months prior Medicaid experience creates opportunities for individuals who otherwise qualify for Medicaid to work and earn more without risk of losing their health care coverage. This alternative is not expected to significantly impact the Medicaid budget as the target population is currently enrolled in Medicaid and the six-month Medicaid eligibility pre-requisite is intended to prevent individuals who are not currently Medicaid eligible from enrolling in the new program. The "graduation" of current Medicaid eligibles to MAPP plus and the new HIPP requirement may even reduce Medicaid costs as a result of higher premium revenue and more employer-sponsored coverage for Medicaid eligibles.

The feasibility analysis of MAPP Plus was shared with DHCF, DWD and CDSD. In general, the analysis was well received. In particular, the HIPP requirement was viewed positively as a mechanism for achieving Medicaid cost restraint without creating an additional burden for program participants. As noted earlier, implementing MAPP Plus may require a CMS waiver, and as such, the possibility of implementation is still being discussed among these groups.

VI. MAPP Recipient and Disenrollment Surveys

Background

Two MAPP recipient surveys were developed to provide information on the MAPP enrollment process and administration of the program from the recipient's point of view, and to measure the program's progress in meeting its goals of supporting employment and independence. The Initial Recipient Survey targets MAPP participants at enrollment in the program, while the Follow-Up Recipient Surveys target program participants after they have had some experience in MAPP. The Follow-Up Survey was administered at six, twelve and twenty-four months following enrollment.[27] The recipient surveys began in the first year of the program and data collection was completed in early 2004.[28]

Evaluation staff drew a monthly sample of participants for each survey. To minimize the burden to MAPP participants, and to reduce the cost of the evaluation study, the evaluation staff selected a random sample of participants for questionnaire mailing and telephone interviewing each month, rather than administering a questionnaire to all MAPP participants meeting the necessary criteria.[29] In addition, all Wisconsin Pathways to Independence (WPTI) participants who were drawn in the MAPP sample were also excluded, as to not overburden those participants with research obligations.

The MAPP Initial and Follow-Up Surveys were field tested in mid-February, 2001, and surveys were mailed to the first cohort of MAPP participants in late February. Subsequent cohorts were drawn monthly, beginning in April 2001. Each cohort consists of two groups – new MAPP participants receiving the Initial Survey, and participants receiving the 6, 12 or 24-month Follow-up Survey. Surveys were mailed by APS staff, and returns were collected and data entered by The Management Group (TMG) as a subcontractor to APS. The majority of surveys were completed via telephone by TMG interviewers as a follow-up to the survey mailings. This step was introduced to assist MAPP participants with completing the survey if necessary. All remaining completed surveys were returned either to TMG or directly to APS.

Data collection was completed as of January 31, 2004, resulting in the following Initial and Follow-up Surveys returns. One thousand three hundred twenty two (1,322) Initial Surveys and 3,370 Follow-up Surveys were mailed. The table on the following page summarizes the cumulative response rates where all contact attempts were exhausted for each survey. [30]

[27] The Initial and Follow-Up surveys were not designed to track a specific sample or cohort of MAPP participants over time, due to the often transient nature of Medicaid eligibility and enrollment. As a result, each recipient survey sample is generally independent of one another, with very little overlap in respondents.

[28] Complete Recipient Survey findings can be found under separate cover entitled: *The Medicaid Purchase Plan: Recipient Survey Analysis, October 26, 2004.*

[29] If too few MAPP participants met the survey criteria for any of the surveys the samples were drawn at 100% of the eligible participants.

[30] The final response rates include surveys sent directly to APS, which were not originally counted as completes by TMG.

Cumulative MAPP Survey Response Rates - April 1, 2001 through January 31, 2004					
Response	**Initial Survey Percentage** (N=1,322)	**6-Month Follow-Up Survey Percentage** (N=1,373)	**12-Month Follow-Up Survey Percentage** (N=1,406)	**24-Month Follow-Up Survey Percentage** (N=591)	**Combined Percentage** (N=4,962)
Survey Completed	35%	33%	30%	32%	31%
Refused*	28%	31%	29%	28%	29%
No Telephone Listing	23%	21%	12%	11%	18%
No Contact (5 attempts)	14%	15%	29%	29%	21%
**"Refused" includes participants who declined to participate in the survey, and participants who told the interviewer they would mail in the survey, but failed to do so. Source: The Management Group (TMG) and APS Healthcare.*					

Based on the sampling procedures and a thorough analysis of key demographic variables, the survey results appear to be an accurate representation of experiences with MAPP across all program participants.

Findings

Where possible, the analysis compared the results from the Initial and Follow-Up Surveys to identify changes over time. However, the results do not represent longitudinal findings for the same group of participants over time; rather, the results are a general indication of recipient responses at enrollment and at 6, 12 and 24 months following initial enrollment.[31]

The Initial and Follow-Up Surveys included questions on the following topics:

- basic demographics,
- recipient understanding of the program,
- financial status/work experience,
- physical, emotional and mental health/level of functioning,
- quality of health care, and
- satisfaction with the program.

A correlation matrix was constructed using earned income, family size, gender, race, medical status codes and rural urban commuting areas (RUCA) consolidated codes to determine if key recipient survey questions were related to any of these factors. Specific attention was paid to earned income. Interestingly, few questions were significantly related to earned income among the initial, six month and twenty-four month respondents; however, several questions were correlated with earned income among the twelve month respondents. Significant correlations are highlighted where appropriate.

[31] 87 individuals responded to both the Initial and the Six Month Follow-Up Surveys, or approximately 19% of the Initial and Six Month Follow-Up respondents. Between any two surveys, a maximum of 110 (6M-12M) people and a minimum of 20 (6M-24M) people responded to both surveys. A small number of useable completed surveys were unidentifiable; therefore, the actual number of respondents who completed any two surveys may be slightly higher.

Understanding of MAPP

Outreach has been identified as a challenge since program inception, and the survey results confirm this. Anecdotal evidence from the interviewers at TMG, as well as the evaluation team, indicates a broad lack of knowledge regarding MAPP. This finding was first noticed among initial and six month survey respondents, but was reinforced by the twelve and twenty-four month respondents, as well, indicating that program tenure has little impact on familiarity with the program.

Of interest to program planners, most survey participants did not know that they were enrolled in MAPP, most likely because their county worker switched them from regular Medicaid to MAPP without notifying them of the change.[32] This scenario appears to be quite common for MAPP participants with previous Medicaid experience. Because the health benefit packages for MAPP and regular Medicaid are identical, there is little impetus to inform the participant of the change to MAPP. Yet, the MAPP work requirement would seem to require that county workers inform their clients about the need to be employed to qualify for the program. It appears that many of these individuals may have transient work histories. As a result, their county workers may enroll them in MAPP without their knowledge if they become employed. This finding may also support the notion that some county workers use MAPP, despite its employment requirement, to qualify people for Medicaid who had lost previous coverage and would not otherwise qualify by noting that they do some type of in-kind work. As noted by the interviewers at TMG, "A number of respondents do not recognize the MAPP name or know how or when they entered the program. This continues to be the most common response [to the survey phone calls]. They know they have Medicaid (or a Forward card), but do not understand that they are accessing it through a program called MAPP." However, TMG noted that respondents who do understand MAPP often "express explicit gratitude for the program, most frequently citing the cost of medications that they would not otherwise be able to afford."

More specifically, respondents to both the initial and follow-up surveys indicate a limited understanding of the MAPP eligibility criteria, benefit structure, and available resources. As stated by the TMG interviewers and reinforced by the survey findings, a significant number of the survey comments suggest that the participants are still not clear on what MAPP is or why they are enrolled in the program. For example, one comment stated, "I do not really understand the program. My social worker just told me I would qualify for this new program which would mean she would not have to review me again until next June." Or, "…MAPP worker has not explained how anything works or what can be expected. Guardian was just handed pamphlets and participant was not even spoken to…"

Numerous respondents feel strongly that MAPP eligibility criteria and enrollment procedures are simply too complex and confusing. Several respondents with college or post-graduate experience noted that they have difficulty understanding the program, and that the eligibility criteria and available benefits are too confusing for many people with disabilities. It's difficult to

[32] An attempt was made to quantify the number of survey participants who did not recognize the MAPP program, and who did not know that they were enrolled in such a program by adding two additional questions to both surveys. However, there was not enough time prior to final data collection to collect the requisite number of responses needed to conduct a valid analysis.

determine if the confusion over MAPP eligibility and benefits is due mostly to a lack of communication between the state and county, and the county and participant; or if the eligibility criteria and benefits are truly too complex to navigate for most people. The data suggest that the lack of outreach and communication between the county and participant are the major contributing factor to any dissatisfaction with MAPP.

More importantly, many of the survey participants are not aware of the work requirement associated with MAPP. According to TMG,

> *Many claim to not know about the work requirement (particularly elderly individuals, who are often worried when they see or hear these questions about work). Some respondents do not recognize that they may indeed be doing "work" according to program definition. For example, after answering "no" to a question about work, "some respondents later describe some activity that may actually qualify as work, like sewing, doing yard work or maintenance in exchange for a rent subsidy or other non-cash payment.*

This finding has wide reaching ramifications for MAPP. The intent of MAPP is to provide people with disabilities who are working or would like to work, with an opportunity to work more, save more and receive the same benefits from work that are available to the non-disabled population, without fear of losing their health benefits. The fact that many survey respondents are unaware of the work requirement raised questions about whether the program is currently serving the original target population. The original target population for MAPP was any disabled person who was, or could have been, engaged in "substantial" work. With few survey respondents aware of the work requirement, it is doubtful that a large number of program participants are engaged in substantial work activities.[33] This finding is supported by the large number of zero and very low wage earners found in MAPP.

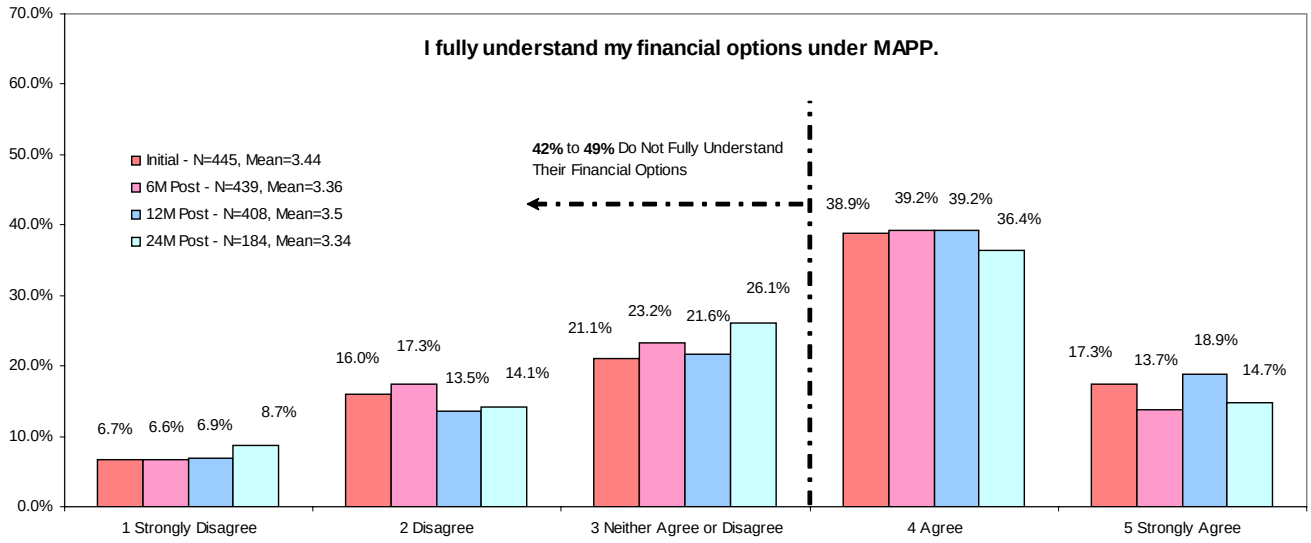
Although the anecdotal evidence suggests that very few survey respondents have a strong understanding of MAPP, the actual survey responses show a slightly better understanding of the program. While there are clearly a significant number of participants who do not fully understand the program, over 50% of respondents to all surveys state that they understand or are comfortable with MAPP.[34] There doesn't appear to be any correlation between tenure in MAPP and increased understanding or comfort with the program. Among most indicators, twelve month respondents showed the greatest understanding and level of comfort with the program, even compared with the twenty-four month respondents.

As a work incentive program, MAPP may also impact participants' financial eligibility for other local, state or federal benefits. As earnings increase, participants may become ineligible for these other benefits. For this reason, it is very important that potential participants fully

[33] The issue of work, and the notion of "substantial work," is discussed in more detail later in the report. To further address the issue of the original MAPP target population, several survey findings in the Recipient Survey Report were analyzed relative to earned income reported in CARES.

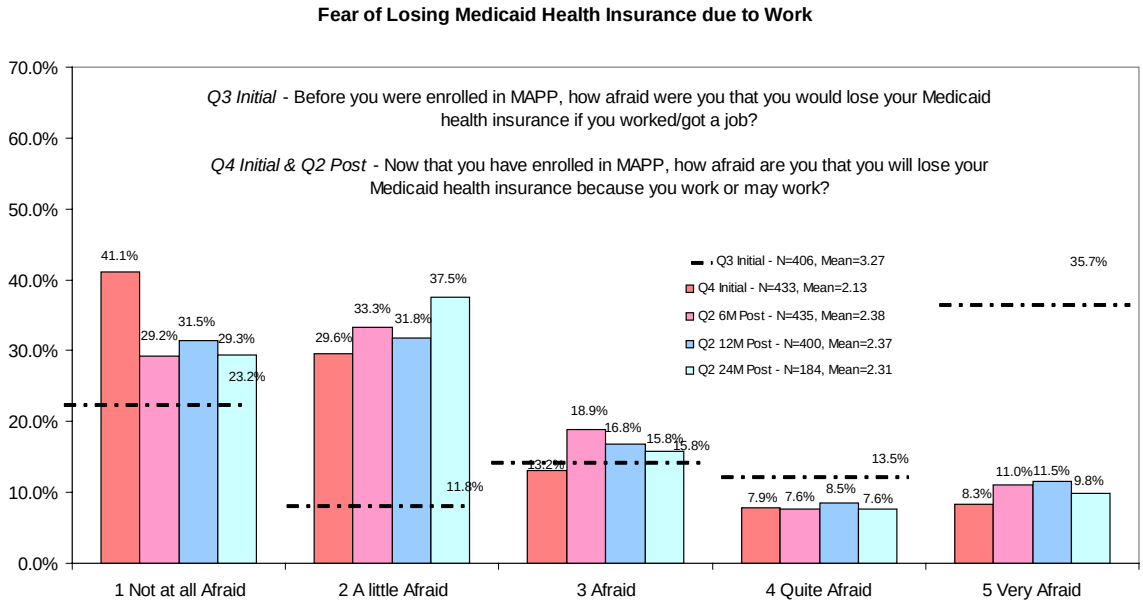
[34] It is possible that the MAPP participants who choose to respond to the Recipient Survey are more aware of MAPP than those who did not respond, implying that actual awareness of MAPP is lower than is indicated by the survey respondents.

understand the financial implications of enrolling in MAPP. The survey comments suggest that many county workers need improvement when fully explaining the financial implications of enrollment in MAPP. Although over 50% of respondents to each survey feel that they understand their financial options under MAPP, there are large percentages of respondents to each survey who are not sure. The chart below illustrates this finding.



MAPP was developed, in part, to address the fact that some individuals with disabilities are not able to work as much as they would like because increased earned income would cause them to lose their Medicaid health care coverage. Therefore, Initial Survey respondents were asked, prior to their enrollment in MAPP, how afraid were they that they would lose their MA coverage if they began working. Prior to MAPP enrollment, over 77% of respondents were at least "a little afraid" of losing their Medicaid coverage if they began working.

This fear appears to diminish with extended participation in MAPP. While 77% of initial respondents were afraid, only 71% of the six month respondents fear losing health care coverage. This percentage continues to decline, with only 69% of twelve month respondents being at least a little afraid of losing benefits. Among twenty-four month respondents the percentage goes back up to 71%; however, this is still lower than the 77% of initial respondents who report being afraid of losing benefits. All respondents report significantly less fear once they are enrolled in the program. The chart on the following page illustrates that the fear of losing health care benefits due to work generally lessens with experience in MAPP, and is significantly diminished after enrollment in the program.



MAPP participants also provided a great deal of positive feedback regarding the program. Through the open-ended questions it was clear that MAPP participants who have been well-informed about MAPP, or who have investigated the program on their own and generally understand the eligibility requirements and program benefits are very pleased with the program. The most common comment in this regard is that without MAPP many of the participants could not afford their medications. Several respondents commented that MAPP is helping them work, save and generally participate actively in the community. These comments are particularly prevalent among the follow-up responses, suggesting that MAPP does have a positive impact on a subset of program participants, particularly after extended enrollment in the program.

Financial Status/Work Experience

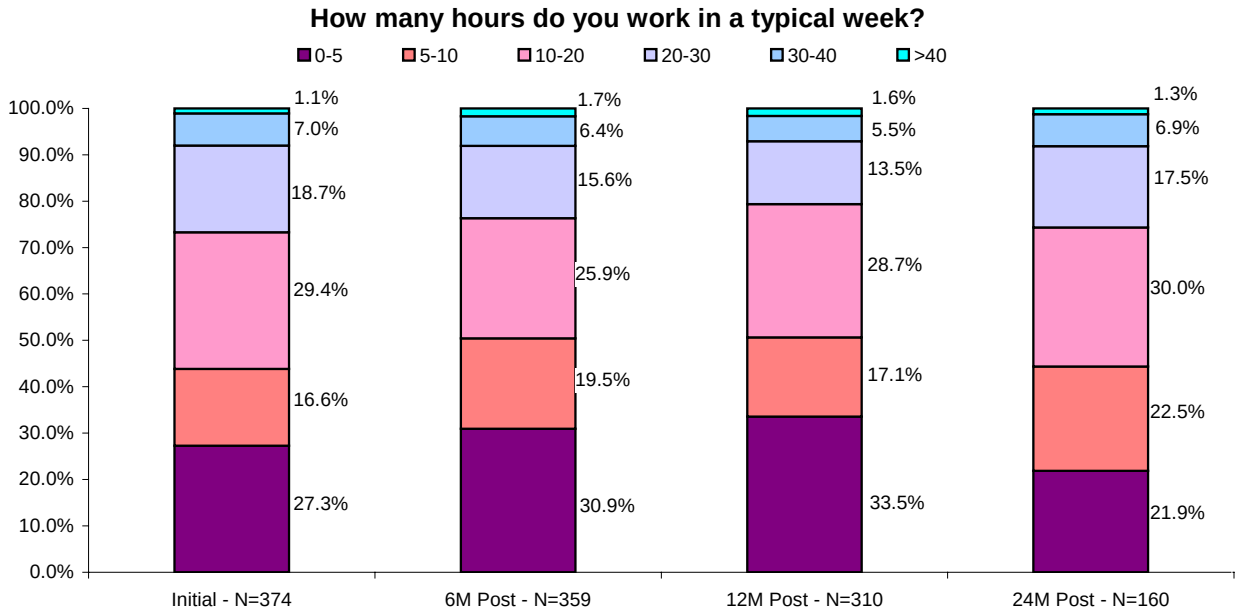
Employment Characteristics

The majority of survey respondents are worried about having enough money. Almost 81% of initial respondents and 82% of six month respondents have some concern about having enough money. Among twelve month respondents, 85% are worried about having enough money; however, this figure drops to 75% among twenty-four month respondents, suggesting that long-term participation in MAPP might help to alleviate some financial concerns.

When asked to identify their sources of income, 85% of respondents to the Initial and Six Month Follow-Up Surveys indicated that they had income from a job or income from disability payments. In comparison, 87% of the twelve month respondents and 89% of the twenty-four month respondents receive income from disability payments or from a job. Among all respondents, disability payments accounted for between 43% and 47% of all sources of income and income from a job accounted for an additional 40% to 45%, suggesting that workers with

disabilities, even after extended time in MAPP, still depend heavily on their disability benefits for support[35].

Respondents were asked how many hours they work in a typical week. Only 6% to 7% of all respondents worked between 30 and 40 hours per week, with less than 2% working more than 40 hours. This finding suggests volatility in the population on ability to work; however, without tracking the same set of program participants over time it is difficult to assess actual work patterns. Based solely on this indicator, it is very difficult to determine if the follow-up respondents are working more than the initial respondents, as would be expected. The data suggest that twenty-four month respondents may be working slightly more than the other respondents; however, the data also shows that six-month respondents are working longer hours than the twelve month group. Complete results are provided in the following chart.



Almost all of those who report working are receiving money as compensation. This finding was unexpected. It had been thought that the high numbers of individuals reporting very low monthly incomes were receiving in-kind compensation in addition to or in place of monetary compensation. However, only 5% to 8% of the survey respondents report receiving in-kind compensation as their sole source of income, and less than 5% of respondents report receiving both money and in-kind compensation.[36] These findings suggest that even participants receiving less than $100 per month in income are typically not receiving in-kind compensation.

Between 15% and 20% of the survey respondents reported being self-employed.[37] Of those respondents who reported being employed by someone else, most (42% to 61%) were employed

[35] The remaining 15% of income comes from investments, support from family/friends, other government assistance or "other" sources.
[36] Since knowing very little about MAPP was identified as a reason for refusing to participate in the survey, it's probable that the survey sample has lost some of the $0/in-kind workers.
[37] These figures represent a subset of the survey respondents who previously indicated that they had income from a job.

by for profit businesses. Twelve month (42%) and twenty-four month (49%) respondents were least likely to be employed by a for profit business. Private non-profit businesses and sheltered employment were the second and third most common employers, respectively.

Approximately 72% of the employed initial respondents have been with their current employer for over six months. Increased tenure in MAPP appears to increase employment stability among program participants. Among six month respondents, 86% have been with their employer for over six months, and among twelve and twenty-four month respondents, 90% have been with their employer for over six months. Although this finding suggests that MAPP does improve employment stability among program participants, over 37% of the twenty-four month respondents report being with their current employer for over five years, suggesting that stable employment may have been established for some MAPP participants before program enrollment.

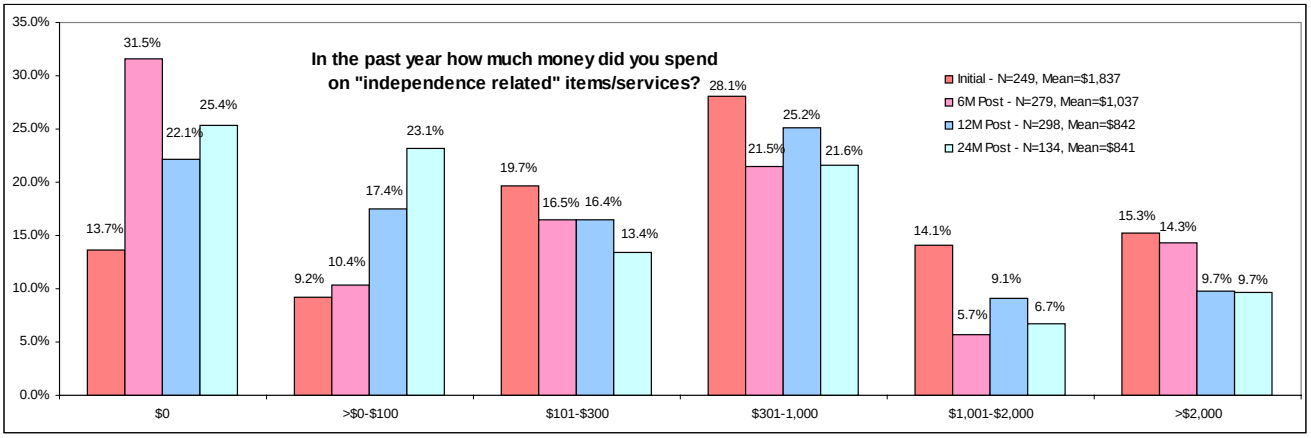
Regarding employer sponsored benefits, it appears that very few survey respondents received employer sponsored health insurance coverage. When asked, "For the past year, who paid for your health care?" most respondents cited Medicaid or BadgerCare, Medicare or self-pay. Over 87% of the follow-up and 71% of the initial respondents identified Medicaid or BadgerCare as a payer for health care in the past year, compared to 71% of the initial respondents. This finding is to be expected given that MAPP is a form of Medicaid coverage. In addition, approximately 60% of all respondents identified Medicare as a payer for health care in the past year. Self-pay was reported by a high of 48% among initial respondents to a low of 39% among twenty-four month respondents. In contrast, only 7% of initial respondents and less than 5% of follow-up respondents reported employer provided insurance as a health care payer in the previous year. These findings suggest that employer sponsored health insurance is not becoming more available to MAPP participants through increased employment opportunities.

To follow-up, respondents to both surveys were asked if private health insurance through their employers had become more accessible after enrolling in MAPP. Less than 8% of respondents indicated that private insurance had become more accessible since their enrollment in the program. This is consistent with findings related to HIPP, where very few MAPP participants are also participating in the HIPP program.

On average, initial respondents have been able to save $159 in the previous six months, while six month respondents averaged $339, a significant increase.[38] Twelve month respondents averaged $264 in savings, while twenty-four month respondents averaged only $211. The twelve and twenty-four month increases were not significant. This finding suggests that MAPP is currently meeting its goal of helping program participants save while enrolled in the program, yet the level of increase is indeterminate based on the reduced savings among the twelve and twenty-four month respondents. Although most MAPP participants do not appear to have the available resources to begin saving at a significant level, MAPP appears to be helping people save slightly more than was possible without the program's benefits.

[38] Only 360 of the 464 initial respondents provided a savings total, and 403 of the 450 follow-up respondents provided this information. The averages cited above include all respondents who reported any savings or indicated $0 savings.

Respondents to both surveys were asked how much they have spent on "independence related" items/services in the past year. Twelve month respondents report spending significantly less on independence items than initial respondents. The reduction in spending for independence related items suggests that MAPP may be providing items/services that individuals had to purchase on their own prior to enrollment, or reducing the need for some independence related items in some other way.[39] The chart below shows the independence related spending for each survey group.



Follow-up respondents were asked to identify the type of independence items they purchased in the previous six month period. Twenty-three percent of the items listed by six month respondents were medications/health related equipment or expenses. Findings among twelve and twenty-four month respondents were similar. While MAPP provides coverage for prescription drugs, "health related equipment" encompasses a variety of independence items, many of which may not be covered by MAPP. In addition, transportation related items, which are not covered by MAPP, accounted for an additional 21% of the spending among the six month group.

Earnings

Respondents were asked to report their earnings in three ways: hourly, monthly and annually.[40] Initial respondents report earning higher hourly wages than their follow-up counterparts; however, the difference in hourly wages is not statistically significant. Self-reported monthly and annual incomes also differ between survey samples, but not significantly.

The entire MAPP population, as identified in CARES, averages $279 per month. Only the six month self-reported survey average was significantly different from the CARES figure[41]. Complete results are found in the table on the following page.

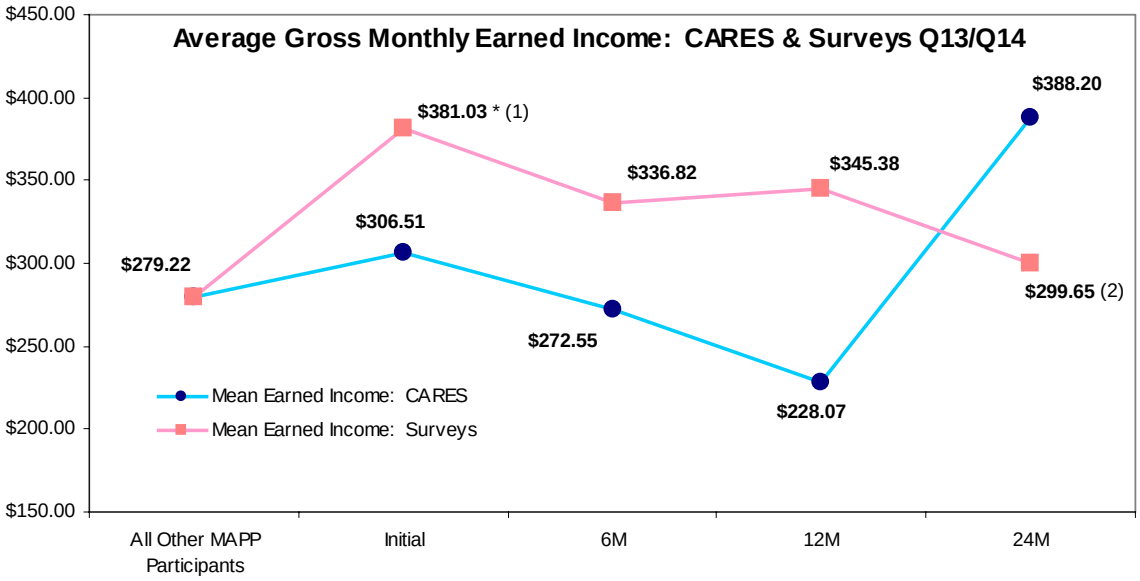
[39] The decrease from enrollment to twenty-four months after enrollment was also not significant; however, this is most likely due to the small number of valid twenty-four month responses.

[40] All questions regarding earnings were first filtered by a previous question asking about employment and also by the type of compensation received for employment. The filters reduce the number of valid responses.

[41] Income in CARES is reported as a monthly figure; therefore, only the monthly self-reported figures were tested for differences.

Self-Reported Earned Income *Hourly, Monthly and Annually*						
Survey	**Hourly**		**Monthly**		**Annually**	
	N	Average	N	Average	N	Average
Initial	272	$8.30	245	$381	211	$3,299
6 Month	240	$6.65	215	$337	179	$3,428
12 Month	189	$6.73	227	$345	187	$3,769
24 Month	112	$6.80	124	$300	96	$4,147

Many of the income findings are contradictory, as illustrated by the graph below. As a work incentive program, longer participation in MAPP was expected to increase earned income; however, the survey findings suggest otherwise. In contrast, the CARES data suggest that extended tenure in the program may increase earnings. Equally as difficult to explain is the discrepancy between the self-reported earnings from the surveys and the earnings reported through CARES at enrollment. Without further analysis of earned income it is difficult to accurately speculate on the causes of these differences.



* Significantly different from all other MAPP participants at the .05 confidence level.
(1) Significantly different from the 6M CARES earned income at the .05 confidence level.
(2) Significantly different from the 24M CARES earned income at the .01 confidence level.

It was also speculated that initial enrollment in MAPP may be related to average earned income, indicating a difference between MAPP participants with early entry into the program (prior to October 31, 2001)[42] and participants who entered the program more recently. Among all participants, as of December 2003, the early enrollees averaged significantly higher monthly

[42] October 31, 2001 was used to allow enough time for this group of enrollees to complete all four of the Recipient Surveys. This analysis was done to determine if the early enrollees responded differently to the Recipient Survey questions than more recent enrollees. Several survey items were tested; however, earned income showed the greatest differences between groups. Very few other significant differences were evident. These are discussed where appropriate in the following sections of the report.

earned income ($360.73) as reported in CARES than more recent enrollees ($260.51). This also holds true among the initial and twelve month respondents, where the early enrollees report significantly higher monthly wages than their more recently enrolled counterparts. In addition, the six month respondents who enrolled prior to October 31, 2001 report significantly higher annual income through their survey responses than the six month respondents enrolling later, $4,790 compared to $2,786. Detailed findings can be found in the table below.

Differences Between Earned Income Among Early and Recent MAPP Enrolllees

by Respondent Group

	Early	Recent
Average Monthly Earned Income Reported in CARES		
Initial Respondents	$359.22 *	$272.44
Twelve Month Respondents	$304.50 *	$197.77
Average Annual Earned Income Self-Reported in the Survey		
Six Month Respondents	$4,789.95 *	$2,786.26

* Significantly higher at the .05 confidence level.

Follow-up respondents did report earning more, on average, in the past year than the initial respondents. Annual income appears to rise steadily with extended participation in MAPP. Six month respondents averaged $3,428 of income from employment in the previous year, whereas initial respondents averaged $3,299. Twelve month respondents reported average annual earnings of $3,769 and twenty-four month respondents reported earning $4,147.[43] This finding fits with the objectives of the MAPP program; however, these differences are also not significant. Given that these increases are not significant, it is still unclear if MAPP is helping people earn more through employment.

Barriers and Job Satisfaction

Initial respondents were provided a list of work barriers and asked to identify all barriers that they had experienced. Poor mental or emotional health was the most common barrier cited by initial respondents (15% of all barriers listed) along with physical limitations (15%), and fear of losing health insurance (14%). Almost 400 of the 464 Initial Survey respondents identified at least one barrier to employment. Poor mental or emotional health and physical limitations were cited by almost half (46%) of these respondents. Complete results can be found in the table on the following page.

[43] This question was also filtered by previous questions on employment and compensation; therefore, the final number of respondents reporting annual income was reduced to 211 initial respondents, 179 six month respondents, 187 twelve month respondents and 96 twenty-four month respondents.

Barriers to Work
Initial Survey Respondents

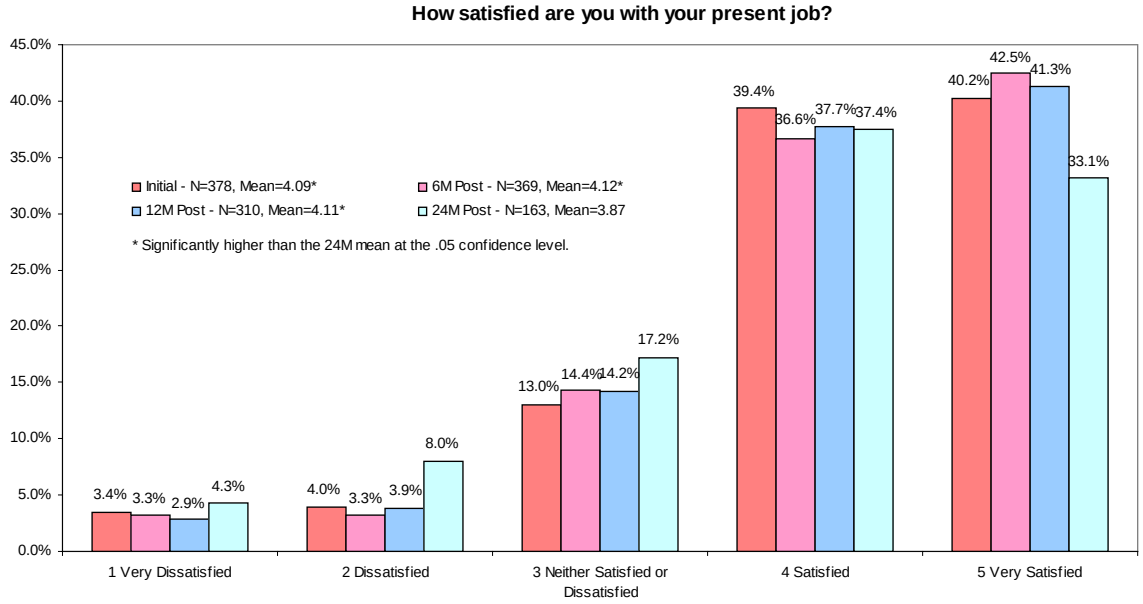
Barrier	Respondents Identifying each Barrier	Percent of All Barriers	Percent of Respondents Identifying a Barrier [1]
Physical limitations	181	14.7%	46.1%
Poor mental/emotional health	181	14.7%	46.1%
Fear of losing health insurance	171	13.9%	43.5%
Frequent illness/hospitalization	105	8.5%	26.7%
Lack of job training	94	7.6%	23.9%
Lack of job experience	87	7.1%	22.1%
Lack of skills	76	6.2%	19.3%
Lack of transportation	72	5.8%	18.3%
Employer discriminatory attitude	66	5.4%	16.8%
Lack of employer flexibility	63	5.1%	16.0%
Can't take time off for health	41	3.3%	10.4%
Lack of job interviewing training	38	3.1%	9.7%
Lack of support from co-workers	28	2.3%	7.1%
Lack of appropriate clothing	17	1.4%	4.3%
Lack of childcare	4	0.3%	1.0%
Other	8	0.6%	2.0%
Total	**1,232**	**100.0%**	

[1] 393 Initial Survey respondents selected at least one barrier to employment. This figure was used as the denominator for this column.

As a follow-up to the listing of barriers to work, initial respondents were also asked to rate the importance of the "fear of losing your Medicaid health insurance" as a barrier to work. Eighty-two percent of initial respondents indicated that the fear of losing their Medicaid health insurance was at least "an important barrier" to work. This finding illustrates the need for MAPP to create an opportunity for people with disabilities to work without losing health care coverage through Medicaid. However, the fact that poor health and physical limitations are ranked above the fear of losing health coverage suggests that it may take more than MAPP to fully support people with disabilities who want to work.

Over 79% of initial, six month and twelve month respondents report being satisfied or very satisfied with their present job. Satisfaction drops to 71% among the twenty-four month respondents. The satisfaction scale ranges from "1" – very dissatisfied to "5" - very satisfied, and the average ratings among the initial, six and twelve month respondents are all significantly higher than the average rating among the twenty-four month respondents. It is possible that satisfaction with employment declines with tenure among this population due to low pay, and a lack of advancement opportunities or new challenges. Low pay is the leading reason for wanting to change jobs among all respondents. Having no chance for advancement is the second leading reason for wanting to change jobs among all but the twenty-four month respondents, where it is the third leading reason. Interestingly, job satisfaction is not correlated with reported earned income, which runs counter to the finding that low pay is the leading reason for wanting to change jobs. This finding suggests that other aspects of employment, such as advancement

opportunities, may be equally as important as pay. The chart on the following page shows job satisfaction scores for each respondent group.



Physical and Emotional Health/Level of Functioning

In general, most survey respondents report being in good or fair health. Between 80% and 83% of all respondents rate their health as at least fair. Few respondents (approximately 13%) to any of the surveys rate their health as very good or excellent. Initial respondents report being significantly healthier than twelve month respondents, on average. In addition, the six month respondents report being significantly healthier than the twenty-four month respondents. It was expected that MAPP would improve health status through employment; however, these findings do not support this expectation.

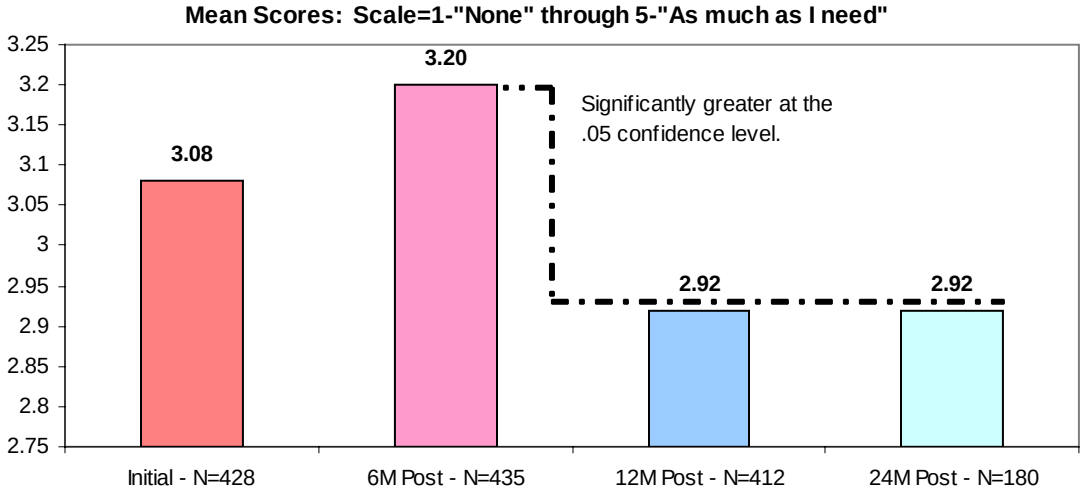
Also, income is positively correlated with one's reported health status. On average, higher income earners report being healthier than lower income earners, supporting the previous findings regarding poor physical and emotional health as barriers to employment.

Several survey questions were included to assess recipient level of functioning and level of assistance received from friends and family members. Approximately one-third of all survey respondents stated that they need no physical help and support from others for day-to-day activities.

Both the initial and follow-up respondents require similar amounts of physical help and support.[44] Of further interest, initial and six month respondents who report higher monthly incomes tend to require less physical help and support from others. However, this trend does not hold for the twelve and twenty-four month respondents. Although independently of income, longer tenure does appear to lessen the need for physical help and support. Level of support required by each respondent group is shown in the chart on the following page.

[44] No significant differences exist between survey respondents regarding the amount of physical help and support needed.

How much physical and emotional support and help for day-to-day activities do you receive from Medical Personnel



The MAPP Recipient Surveys also included the SF-12® measurement set for self-reported health status. The SF-12® is a subset of the larger SF-36® Health Status Survey. The SF-12® measures the same eight health concepts as the SF-36®. These health concepts include the following:

1. Physical Functioning – 2 Items
2. Role limitations due to physical health problems – 2 Items
3. Bodily Pain – 1 Item
4. General Health – 1 Item
5. Vitality (energy/fatigue) – 1 Item
6. Social Functioning – 1 Item
7. Role due to emotional problems – 2 Items
8. Mental Health (psychological distress and psychological well being) – 2 Items

These eight concepts are combined to generate two standardized health scores, the Physical Component Summary (PCS) and Mental Component Summary (MCS).[45] Using SF-12® scoring software provided by Quality Metric, PCS and MCS standardized scores were generated for each recipient survey. Each score was then compared with all other scores to determine significant differences between groups of survey respondents. In addition, the standardized PCS and MCS scores were compared to the general US population based on data provided by Quality Metric.

In all cases, MAPP survey respondents report significantly lower health status (i.e., lower PCS and MCS scores) than the general public. Mean PCS scores for each survey group were at or below 42.82, as compared to a mean of 50.12 for the general public. Mean MCS scores were no

[45] SF-12®: How to Score the SF-12® Physical and Mental Health Summary Scales. John E. Ware, Jr., Ph.D., Mark Kosinski, M.A. and Susan D. Keller, Ph.D. Quality Metric Incorporated, Lincoln, Rhode Island and The Health Assessment Lab, Boston, Massachusetts. Third Edition: September 1998.

higher than 44.17 among the survey groups. In contrast, the mean MCS score among the general public is 50.04. Mean scores for the SF-12® are standardized so that each year a score of near 50 represents the mean level of health for the general public. As would be expected, MAPP participants exhibit lower physical and mental health status scores than the public average.

As discussed earlier, it was hoped that MAPP would improve the physical and mental health of program participants; however, the SF-12® findings do not support this expectation. In only three instances were the SF-12® scores significantly different between groups of survey respondents, and in each case, those with longer MAPP tenure exhibited lower health status scores. These differences were evident between the initial and twelve month respondents, and the six month and twelve and twenty-four month respondents. Significant differences in self-reported health status were only apparent among the PCS scores. Mental health appears stable across each survey response group.

Taken as a whole, these health status indicators appear to represent a disabled population capable of work, but in need of some physical and/or emotional support from others. Continuous efforts are underway in 2005 to better assess functional status and target specific disabled populations where MAPP could be most effective, and address issues with MAPP that would make it more effective for people with more serious limitations who want to work.

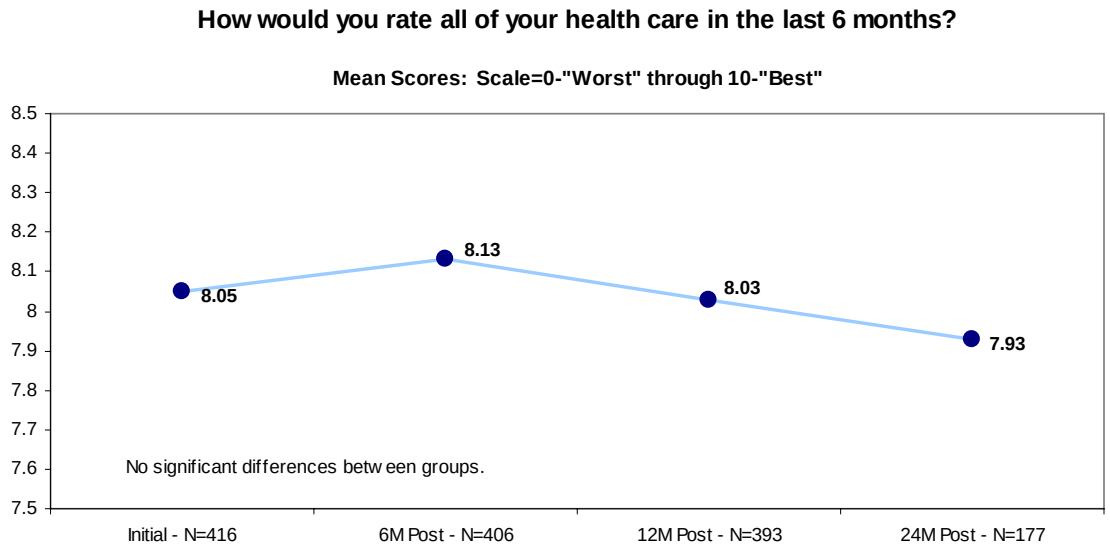
Quality of Health Care

MAPP participants were also asked to rate their health care providers. Beginning with the "health care provider who knows (them) best[46]," respondents were asked to rate that provider on a scale from 0 (worst health care provider possible) to 10 (best health care provider possible). MAPP participants seem very satisfied with their primary providers. Average primary health care provider satisfaction scores ranged from 8.26 among the twenty-four month respondents to 8.34 among the twelve month respondents. Wisconsin Medicaid fee-for-service (FFS) respondents to the 2002 Consumer Assessment of Health Plans (CAHPS) survey rated their personal doctors an average of 8.72 on the same eleven point scale[47]. Less than 3% of all respondents rated their primary health care provider a three or lower.

Results were very similar for care provided by others besides the participants' personal doctors or nurses. The average rating of care given by providers other than a personal doctor or nurse was 7.9 among the initial, six month and twelve month respondent groups, as compared to 8.1 among twenty-four month respondents. **ALL** health care was rated similarly among each group of respondents, as well. Initial and six month respondents rated their overall health care an average of 8.05 and 8.13, respectively. While twelve and twenty-four month respondent rated their overall health care 8.03 and 7.93, respectively. Among CAHPS FFS respondents, all health care providers averaged 8.5, slightly higher than the average rating provided by the MAPP participants. Comparisons between the initial and follow-up respondents on these indicators

[46] The health care provider could be a general doctor, a special doctor, a nurse practitioner or a physician assistant.
[47] These findings were obtained from internal Department of Health Care Financing reporting on the 2002 CAHPS survey. The CAHPS FFS population is a similar, but not identical, comparison group in relation to the MAPP population. Commercial purchasers of insurance tend to rate their providers lower yet, possibly based on higher expectation of care, and given that the MAPP population is a working disabled population fitting somewhere between the average commercial and Medicaid populations, one would expect their ratings to be slightly lower than the Medicaid population as a whole.

show no statistical differences in their ratings of health care.[48] The chart below illustrates the overall healthcare rating for all groups of respondents.



In general, survey participant comments are very positive regarding the quality of their healthcare. However, one recurring complaint regarding access to healthcare was particularly prominent among the twelve and twenty-four month respondents. Several respondents were upset that they could not find many, and in some cases any, dentists to accept their Medicaid coverage. As noted by one respondent, "The only thing I have a problem with is MA does not pay for dental services. I have to pay cash. If I tell a dentist I have MA they will not serve me even if I say I will pay cash in advance. When I lived in MN (Minnesota) I had MA with dental services included. Why can't I find a dentist in WI that will accept MA?" Similar sentiments were noted by several of the follow-up respondents.

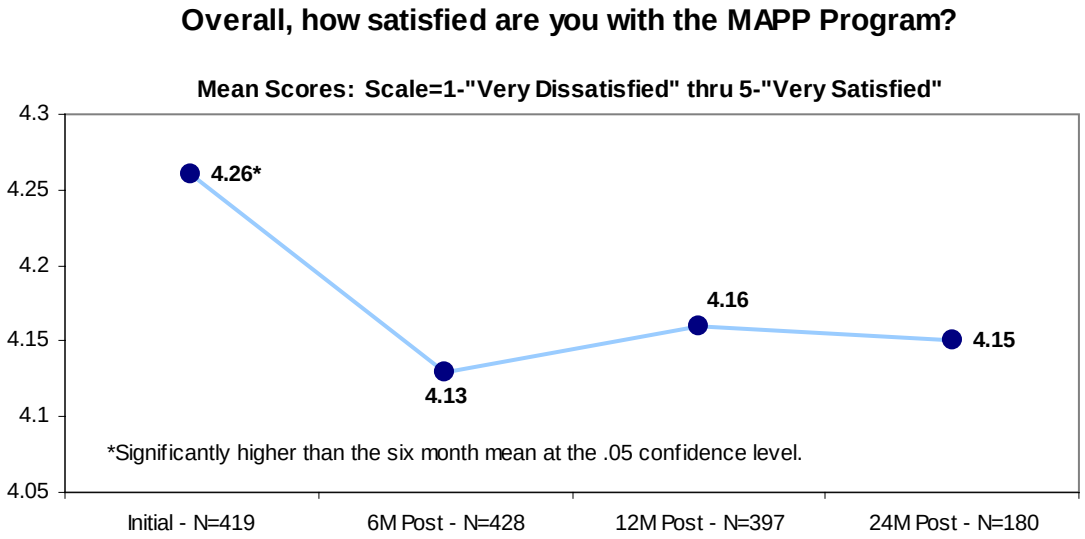
Overall Program Satisfaction

The majority of survey respondents report being satisfied with the MAPP program. Eighty-seven percent of initial respondents were either satisfied or very satisfied with MAPP, a figure which drop to 84% among six month respondents and below 83% among twelve and twenty-four month respondents. Although each group of respondents is generally satisfied with MAPP, follow-up respondents are less satisfied with the program, suggesting that long-term experience with MAPP somehow diminishes participant's satisfaction with the program.[49] However, given the large number of respondents who report not knowing that they are enrolled in MAPP, or having limited knowledge of the program, it is possible that many respondents were actually considering their general Medicaid benefits/experiences when asked about satisfaction with MAPP. In either case, respondents are very satisfied with their services, and over 96% of all

[48] When interpreting these questions, please note the following comment from the TMG interviewers: "Question about quality of health care from other health care professionals is often difficult for respondents to answer. They often want to rank other providers individually, not give a collective ranking. They tend to have very individual feelings about these people, who often include one or more people coming into their homes."

[49] Only the initial and six month respondents are significantly different (.05 confidence level) on overall satisfaction with MAPP.

respondents would recommend MAPP to other people with disabilities. The chart below illustrates overall satisfaction with MAPP by all survey groups.



Satisfaction with MAPP is generally very high. Review of the open-ended survey comments provides a great deal of positive feedback about MAPP, including,

> *The MAPP plan probably saved my life. When I got married in October 2000 my SSI and Medicaid was taken away. Even with my husband's insurance there was no way we could afford the medical care I need, or the prescription drugs. But with MAPP I got Medicaid back, and working the few hours I do and helping other people while doing it has shown me that maybe I'm not completely worthless after all. You should keep this going! Otherwise, I have no insurance.*

Yet, there are some specific aspects of the program that seem to contribute to dissatisfaction, such as the work requirement and the premium requirement. For instance, one respondent wrote,

> *MAPP is good, but my county worker told me that if I do not work I will lose my Medicaid. If I apply for stait [sic] Medicaid I would have $1000/month spend down. It is very hard for me to work but I need my health insurance. I receive very little income from a widow pension and SS, barely enough to pay for my rent and food. I think they (state) should re-think the income limit for Medicaid. This is a circle I keep going around and around but can't get ahead. I have worked many years as a nurse. Now I am disabled and I don't think I should have to work to get health insurance.*

This quote reflects the sentiments of many survey participants: "Why is MAPP only available to the working disabled? What happens to the non-working disabled who don't qualify for Medicaid under other eligibility categories, or who can't afford spend downs or other coverages?" It is clear that most MAPP participants have a difficult time with the nuances of a work-incentive program, such as MAPP, when it appears to them as simply another health

insurance program sponsored by the state. This issue has not been thoroughly addressed for participants or county workers and will continue to confuse current and potential MAPP participants. Concerns about the premiums are discussed in more detail as part of the Disenrollment Survey analysis to follow.

Conclusions

The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.

MAPP does appear to be allaying some of the fear associated with losing healthcare benefits because of increased employment. All follow-up respondents report less fear of losing healthcare benefits than do initial respondents. Although MAPP appears to be reducing fears related to returning to work or increasing work, it is clear that most respondents do not consider MAPP a work incentive program, but rather, another option under which they can receive state sponsored healthcare coverage. Many of the open-ended comments show extreme appreciation for the program, as it is the only health insurance available to them, but very few mention anything about work, except to say that the work requirement is confusing and should be dropped.

Assessing actual earnings among MAPP participants is difficult; however, the recipient surveys do provide some indication of average MAPP earnings and earning trends over time. Among survey participants, average self-reported earned income was greater than $280 per month. More importantly, average annual income as self-reported in the recipient surveys shows a steady increase over time. Initial respondents reported earning $3,299 per year, whereas, the twenty-four month respondents reported earning $4,147 per year. Although annual income is steadily increasing over time, the differences between groups are not significant. Given that no distinct pattern emerges regarding earned income, it is difficult to state with any certainty that MAPP is helping people earn more money over time. However, the survey findings do suggest that MAPP is having some effect on participants' earnings. Further analysis among income subgroups would be required before definitive determinations could be made regarding increased earned income.

Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.

Unfortunately, most respondents had saved nothing in the past six months. This may be less a reflection on the program, and more an indication of the socioeconomic status of the MAPP participants. MAPP participants are generally very low income with significant health and long-term care needs, and many are on fixed incomes with very little income from outside sources. These circumstances leave little opportunity to save. On average, initial respondents were able to save $159[50] during the previous six months. Six month respondents were able to save significantly more ($339) in the six months prior to completion of the survey, implying that MAPP does help those who can afford to save actually save more. Twelve and twenty-four month respondents were also able to save more, but not significantly more. There is very little opportunity to save among MAPP participants, yet the program is meeting its goal of assisting those who can save to save more.

Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

MAPP has been effective in improving the health of its participants, encouraging work and providing/maintaining health care coverage in many instances. However, some difficulties in these areas do remain. Most respondents report being in fair or good health at the time of the surveys; however, few rate their health as very good or excellent. More importantly, initial respondents report being significantly healthier than the twelve month respondents, and the six month respondents report being significantly healthier than the twenty-four month respondents. This finding is exactly the opposite of what was expected when MAPP was first implemented four years ago. By helping people work more and become more self-sufficient, it was hoped that MAPP would also help to improve participants' overall health and functioning; however, MAPP does not appear at this time to be impacting self-reported health status. Self-reported functional status remains relatively constant among the survey groups, as well.

The only significant relationship regarding health and functional status appears to be with income.[51] In general, higher earners tend to be healthier and more functional. The question then becomes, did this group enter the program as a healthier more functional group capable of working more or at more skilled positions, or has MAPP allowed for increased/improved employment, which in turn leads to better health and functioning? Given the previous results, it is most likely that MAPP is simply more effective for people whose disabilities, by nature, allow them to fulfill a wider variety of jobs.

The most common barriers to work were both health related. Physical limitation and poor mental/emotional health were identified by initial respondents as the leading barriers to work, each constituting 15% of all identified barriers. These barriers were identified by approximately 39% of all initial respondents. Fear of losing health insurance (14%) was the third most common barrier to work among initial respondents, indicating that MAPP has not eliminated this fear completely. In addition, another health related barrier, frequent illness/hospitalizations, ranks as the fourth most common barrier to work. This suggests that physical, mental and emotional

[50] The savings figures represent anyone who responded to the question, "How much did you save in the last 6 months?" and therefore includes many respondents who indicated that they saved $0.

[51] This relationship exists with other functional indicators (questions) on the Recipient Surveys, not the SF-12 questions included in each survey.

limitations are the main barriers to employment for the MAPP participants, and although health can be improved, many of these limitations will remain difficult to overcome.

There are some indications that MAPP is allowing program participants to live fuller lives than before enrollment. For example, twenty-four month respondents report feeling "down-hearted and blue" significantly less often than initial and twelve month respondents. Also, twenty-four month respondents report that their health stops them from getting around significantly less than do the twelve month respondents. However, MAPP can only influence specific aspects of participant's lives, and as such, it is difficult for MAPP to have a significant impact on participants overall happiness and fulfillment.

Based on the open-ended survey comments, along with other independent analyses conducted in 2004, MAPP has generally exhibited the same level of efficiency as most other Medicaid sub-programs, with the exception of outreach. The automation of MAPP in CARES appears to have created a much more efficient enrollment process, resulting in a dramatic increase in program enrollment. However, education and outreach regarding MAPP remain minimal and the information dissemination that does occur is generally disjointed and overly dependent upon the discretion of the counties. More formalized education regarding the benefits and enrollment criteria of the MAPP program would be beneficial for current and future program participants.

MAPP appears to be very equitable across age, race and gender. However, geographic location appears to affect participants' experiences in the program. Depending upon the county where the participant is located, MAPP may either be embraced and encouraged or ignored and in some cases discouraged for various reasons. In addition, the existing premium formula often affects participants with mental illnesses disproportionately. This group often has few, if any, IRWEs and MREs to claim against their premium liability, as their only expenses are their medications, which are already covered by MAPP and therefore not deductible. As a result, they typically pay very high premiums to remain in the program and on their medications. If the premium becomes prohibitive, they often lose their coverage and stop taking their medications, which leads to a continued cycle of unemployment and instability.

Disenrollment Survey

A third survey regarding disenrollment from MAPP was also developed and administered over the first three years of the program. The Disenrollment Survey was first mailed in November 2001, with data collection completed by March 2004. The Disenrollment Survey contains seven questions focusing on reasons for disenrollment from MAPP, satisfaction with MAPP while enrolled, and comments regarding the participant's experience with MAPP.

The Disenrollment Survey sample was drawn quarterly between November 14, 2001 and March 8, 2004. To be eligible for the Disenrollment Survey, a MAPP participant would have had to disenroll from the program at least one month prior to the survey mailing date, but less than three months prior to the mailing date, have not received a previous mailing for any other survey in the two months prior and had not participated in a WPTI survey during their MAPP enrollment. Disenrollment Survey candidates were also contacted by TMG as a subcontractor to APS, approximately two weeks following the disenrollment mailings to offer assistance to any

candidate who had not yet returned their survey. Beginning with the June 2003 mailing, a second mailing was also conducted to increase the response rate of the survey.

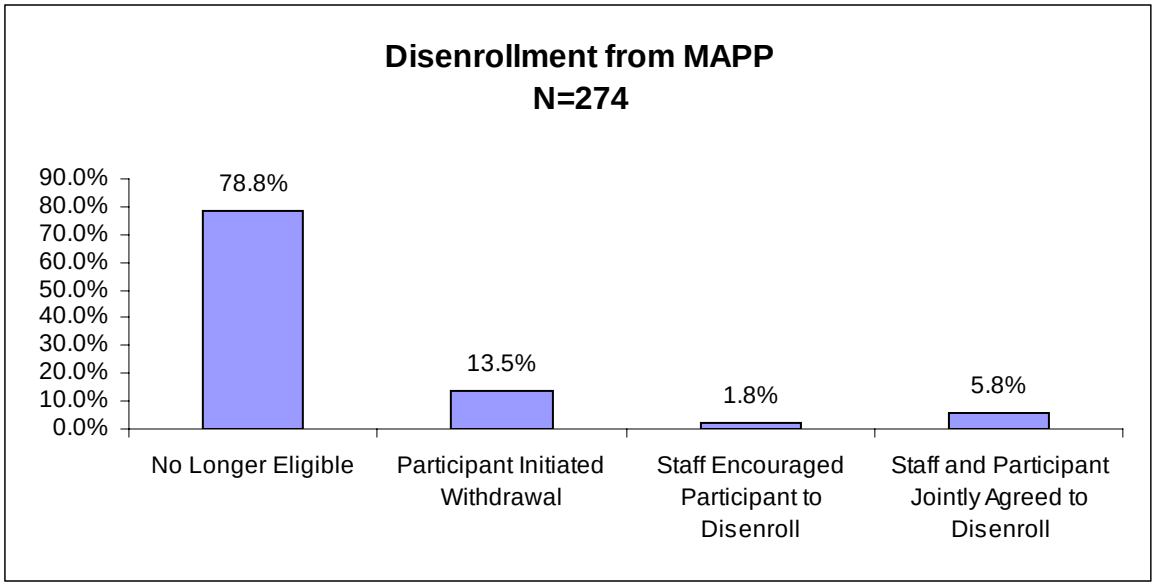
Through eleven quarterly mailings, 1,550 MAPP participants were targeted for the Disenrollment Survey. Final returns, including returns associated with follow-up calls and second mailings, totaled 357, for a final response rate of just over 23%. Although the Disenrollment Survey response rate is relatively low when compared to the overall response rate for the Recipient Surveys (31%), it is adequate considering the nature of the survey. Given that all respondents to the Disenrollment Survey are no longer participating in MAPP and have little incentive to complete a survey regarding their past experience with the program, the final response rate is within expectations. Also, some participants do leave the program due to death and could not be identified and removed from the sample prior to the survey mailing.

Findings

The Disenrollment Survey consists of seven questions covering reasons for disenrollment from MAPP, meeting expectations for retaining health care and providing opportunities to save, overall satisfaction with MAPP, and other general comments regarding participation in the program. Where possible, all available information from other sources such as MEDS and CARES was utilized to gather indicators that might help to explain findings from the Disenrollment Survey.[52]

When asked to describe their disenrollment from MAPP, most (79%) respondents indicated that they had stopped participating because they were no longer eligible. In the majority of the remaining cases, the participant could have continued in MAPP, but chose not to. The following chart shows the broad reasons for disenrollment provided by the respondents. In each case other than the "no longer eligible" group, the respondent could have continued, but did not either at their choosing or with the persuasion of staff.

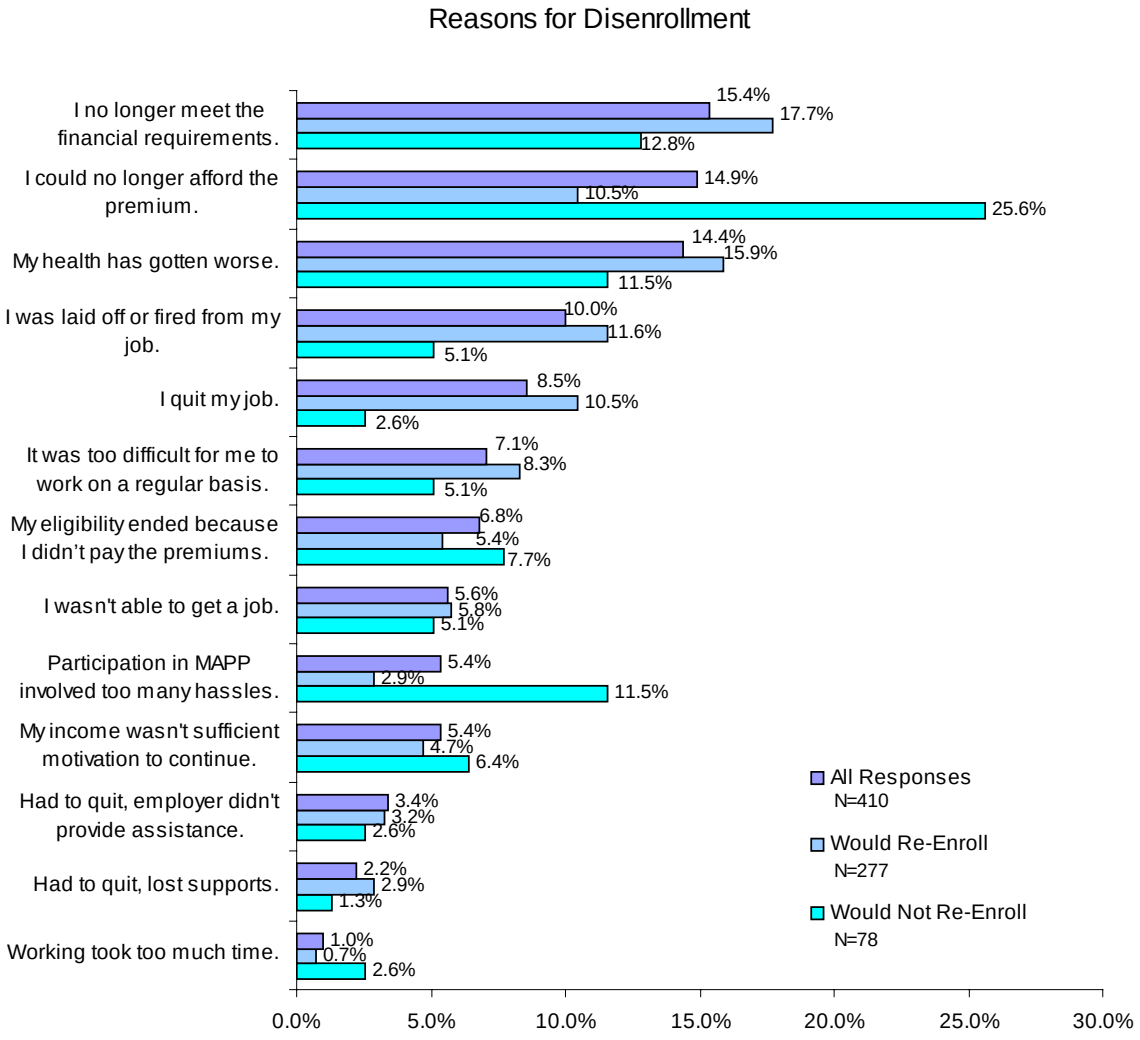
[52] In most cases the additional data was used to analyze the demographic makeup of the survey participants and how any differences might have affected the survey responses. A more detailed discussion of these findings can be found under separate cover in the report entitled: Medicaid Purchase Plan: *Disenrollment Survey Analysis, November 2004.*



Survey respondents were then given the opportunity to select more specific reasons for disenrollment, including no longer meeting the financial requirements, no longer being able to afford their premium, and several reasons related to health and general difficulties with working. Respondents were provided with a list of 13 possible reasons for disenrollment from MAPP and asked to select all that applied to their disenrollment from the program. They were also provided an opportunity to write in other possible reasons for their disenrollment that were not captured in the choices provided on the survey, or simply to explain their selections.

Two hundred and thirty-six[53] respondents provided 410 reasons for disenrollment from the MAPP program. The most common response was "I no longer meet the financial requirements.", accounting for 15% of the total responses. This was closely followed by "I could no longer afford the premium." (15%) and "My health has gotten worse." (14%). The remaining reasons for disenrolling each accounted for 10% or less of the total. However, when combined, the following work related barriers contributed to a large (24%) percentage of disenrollments: "I was laid off or fired from my job." (10%), "I quit my job." (8.5%), and "I wasn't able to get a job." (5.6%). Another 7% of respondents also noted that "It was too difficult for me to work on a regular basis.", and almost 6% of the respondents quit their jobs because their employer didn't provide assistance or they lost their supports. The chart on the following page provides the distribution of reasons for disenrollments

[53] These 236 respondents represent 66% of the 357 total respondents to the survey. The remaining respondents did not select one of the available reasons for disenrollment, but in most cases selected "Other" and described their reason for disenrolling in the space provided on the survey.



As might be expected, among the respondents who said that they would not re-enroll in MAPP given the chance, the most frequent reason (26%) for disenrolling was that they could no longer afford the premium. Similarly, 12% of these responses suggested that participation in MAPP involved too many hassles. In comparison, only 11% of disenrollment reasons from the respondents who indicated that they would re-enroll in MAPP were due to premium payments, and only 3% suggested that MAPP involved too many hassles.

One hundred and ninety-two respondents provided their own reason for disenrolling from MAPP by writing a brief narrative describing their disenrollment. The majority of the descriptions fit into one of the following categories:

- The premiums became too expensive due to several factors related to increased earned or unearned income.
- The participant got married, which increased income above the eligibility threshold.

- The participant became eligible for some other benefits, such as Medicare, a Medicaid waiver or regular Medicaid.
- The participant's health deteriorated and they could no longer work or lost their job.
- Other family circumstances interfered with working or other eligibility criteria, such as taking care of a sick relative or moving out of state with family.
- Several program participants did not know that they were on MAPP, and consequently were surprised to see that they had been disenrolled.
- There was some type of miscommunication with a caseworker or poor follow-up by the consumer or caseworker, which led to a disenrollment.
- In some cases, the participant either began working and no longer needed MAPP coverage, or they earned too much to qualify once they began full-time employment.
- Some participants left the program due to death.

By far the most common reason cited for disenrolling from MAPP among the write-in responses was that the premiums were simply not affordable. For example, one respondent wrote, "I am not medically needy at this time and my MAPP premium (monthly) would be higher than I would spend in 6-12 months. This is why I am not enrolled at this time." A second added, "I went from medical assistance to a $375.00 payment plan. It was 1/3 of my income. I choose paying my monthly bills and eating over the MAPP plan." Reflecting a similar sentiment, another respondent wrote, "Very hard to pay for because you had to skip bills and cut food. If the premiums were cheaper, it wouldn't be so hard." And finally, another respondent indicated that Medicare and a supplemental policy through American Family Insurance was much cheaper than their MAPP premium. These four individuals average over $1,137 in unearned income, placing them in a position to have significantly higher premiums than MAPP participants with lower unearned income. The average premium for this group was $388 based on their most recent month of eligibility through March 2004.

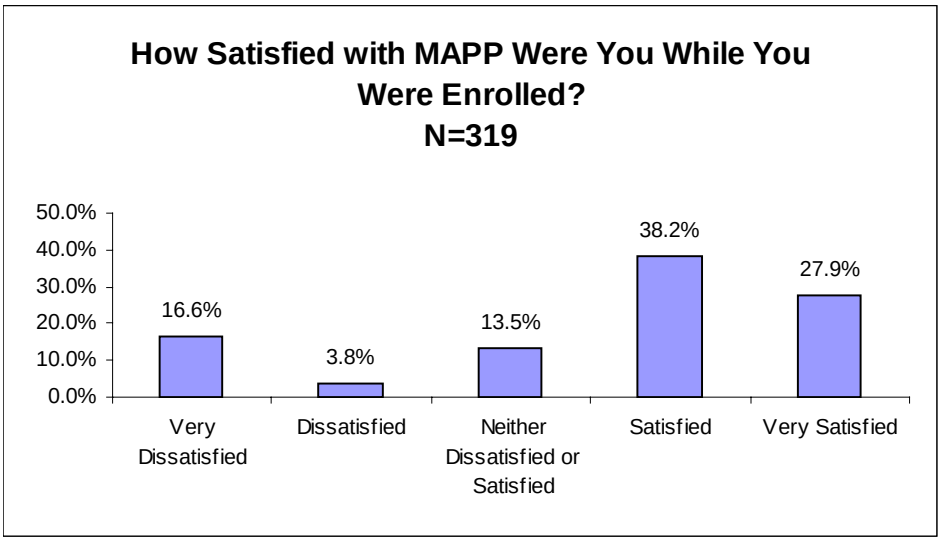
When asked if MAPP was meeting their expectations for retaining their health insurance, 89% of the respondents indicated that it had, while 11% indicated that it had not met their expectations (see chart on the following page). Respondents were given an opportunity to explain why the program had not met their expectations for retaining their health insurance, and 42 respondents provided explanations. These explanations ranged from complaints that the program is too complex to easily or accurately navigate, to assertions that coordination with other benefits, such as Medicare and Social Security, is poor. When asked if MAPP met their expectations for saving while working, 61% of the respondents said yes; however, over 24% said no. Fifteen percent indicated that they were not working.[54]

The respondents who indicated that MAPP did not meet their expectations to save generally indicated that there is simply no extra money for savings. One respondent described their financial situation as a "hand-to-mouth" existence, a sentiment that was echoed by many of the

[54] It is possible that the non-working group was enrolled in the Health and Employment Counseling (HEC) program and seeking employment during their participation in MAPP; however, based on the small number of HEC enrollees through March 2004, it is unlikely that all of these individuals were enrolled in HEC.

other respondents. Working at a substantial level for many of the people with disabilities that make-up the MAPP population is simply too difficult. The job market is being squeezed by a dip in the economy where moderate and high paying jobs are increasingly less available. When asset spend-downs and premiums are added to the employment and benefits equations, there often is little or nothing left over for savings. Based on feedback from the Disenrollment Survey respondents, MAPP would be well served by adding to the employment resources already available through the Health and Employment Counseling (HEC) program (see detailed discussion in the HEC section below). Most MAPP participants require some assistance with locating and maintaining adequate employment, and without a coordinated effort at the state and local levels to assist participants, many participants settle for very low paying jobs that do not allow for savings, or simply give up on the process and inevitably drop out of the program.

Over 66% of the Disenrollment Survey respondents report being satisfied or very satisfied with MAPP. However, 17% of respondents report being very dissatisfied with MAPP. The chart below illustrates these findings.



In comparison, over 80% of respondents to each of the Recipient Surveys reported being satisfied with MAPP. As a follow-up to program satisfaction, Disenrollment Survey respondents were asked if they would re-enroll in MAPP in the future. Almost 88% of the respondents stated that they would re-enroll in MAPP in the future, leaving 12% who would not. Respondents who indicated that they would re-enroll in MAPP were also significantly more satisfied with the program than those respondents who said they would not re-enroll.

Although satisfaction with MAPP is generally high, issues remain that affect full utilization of the program. Review of the open-ended Disenrollment Survey comments provides a great deal of insight into the positive and negative aspects of MAPP.

Some survey respondents report in their comments that MAPP has worked well for them in its current format. When asked "How could we make the MAPP program better?", several respondents simply stated that it is "Good the way it is.", or reflected similar sentiments.

However, several suggested improvements were also provided by respondents. The need for these improvements generally fall into three categories: 1) cost of premiums, 2) complexity/coordination of program, 3) lack of information available about the program.

As noted earlier, many MAPP participants find the cost of premiums to be prohibitive, particularly those participants whose earned income pushes them past the premium threshold and who also have high unearned income. Because 100% of a participant's unearned income is counted towards their premium amount after deductions, this group can go from paying no premium to a very high premium with only a small increase in earned income. For example, one respondent wrote, "Make income guidelines more affordable. Someone making $200 a month over the income (premium) limit should not have to pay $550/month for premiums. This program doesn't help disabled people in my income bracket." Another respondent stated that their premium amount went from $0 to $600 with an increase in income and that smaller "stepping stones" for premium increases are necessary. Despite the high cost of premiums for some participants, many still feel that the program is valuable as illustrated by the following comment. "Lower the payments. $250 is just a little too much for me, but it's a very good program. I'm very happy I have (had) it. Keep up the good work."

Several respondents also noted that the MAPP program feels overly complicated and that coordination between Medicare, Social Security and Medicaid benefits through MAPP is poor. One respondent stated, "It would be a good idea to make the MAPP program more compatible with the various county and federal programs for disabled individuals." Participants seem confused by the vast array of local, state and federal services available to them and the accompanying eligibility criteria. Even with Medicaid, participants become confused and often do not know how they qualify for Medicaid benefits or why they have been dropped from MAPP and possibly moved to another Medicaid eligibility category or placed in a waiver program. Making matters more complicated is the delicate balance that must be maintained between Social Security benefits and Medicaid benefits. Several respondents mentioned that they have had difficulty understanding how each of their state and federal benefits affect one another. As a result of this confusion, some MAPP participants have missed premium payments or let their eligibility lapse in some other way.

Lastly, respondents clearly indicated that a lack of understanding of MAPP exists at the county level and this lack of knowledge of the program hinders enrollment and encourages disenrollment, as well. A lack of confidence in their county workers is evidenced by one respondent who was so surprised by his sudden large increase in premium, due to a $22 increase in income, that they questioned if their "social worker doesn't understand the program." Other respondents simply state that very little information is available regarding MAPP, and coupled with an apparent lack of understanding among many county workers, they have few options to improve their understanding of the program and the benefits that it provides. For example, one respondent stated, "Information dissemination is scarce. When I applied, no one in Superior knew about it." and another respondent stated, "Simplify benefits more clearly in brochures and have staff explain." When discussing re-enrolling, one respondent simply stated that "If I had information about it I would consider it." And finally, a retired nurse who was on MAPP suggested that in her county case workers were getting bonuses for reducing their rolls, which in turn lead to discouraging people from participating in MAPP. Although there has been no other

evidence to suggest this is happening, the perception that it is occurring is troublesome and may impact participants' decisions to enroll or disenroll from the program.

Conclusions

To summarize, MAPP has been successful in many respects, such as freeing participants to, at the very least, pursue employment with the aid of medical and prescription drug coverage. The Disenrollment Survey findings also suggest that most participants are satisfied with MAPP, yet are forced to disenroll because they lose eligibility, not because they want to leave MAPP. However, the survey responses also suggest that several key barriers exist that contribute to disenrollments from MAPP[55]. These barriers include:

1. The existing premium structure, which strongly discourages increasing earned income for those participants with large unearned income and no current premium, as the increase may cause a significant increase in their required premium;
2. An overall difficulty with obtaining and maintaining employment to remain eligible;
3. A general lack of understanding of how the program works and how it affects other public benefits; and
4. A very complicated network of disability related benefits and eligibility criteria that is not well coordinated at the county level, especially for working individuals with disabilities.

Although each case is unique, these four factors appear to be the driving force behind the majority of elective disenrollments from the program. Each factor also directly impacts the three stated goals of the program.

Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.

For individuals with high levels of unearned income, even small increases in earned income may cause very large increases in premium liability. As a result, the high premiums threaten the feasibility of continued participation, which contradicts the goal of encouraging people with disabilities to earn **more** income without risking loss of health and long-term care coverage.

Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.

Unfortunately, the Disenrollment Survey respondents reinforced the Recipient Survey findings that suggested people on MAPP simply do not earn enough in relation to their expenses to save a significant portion of their income. In fact, it appears from the data that very few MAPP participants are capable of saving at a substantial level, if at all. However, MAPP does seem to slightly increase the likelihood of saving among participants in the program.

Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

[55] It should be noted that the conclusions presented here represent findings from a sub-set of MAPP participants who disenrolled from the program and in some cases were forced to leave the program due to eligibility requirements.

The complexity of the Medicaid system is a barrier to providing an effective, efficient and equitable program for many people with disabilities. The complex array of public benefits can easily overwhelm consumers, particularly in the case of MAPP where there is evidence that some ES workers are either not well informed about the program or exhibit apathy towards enrolling people into MAPP. As a result, several participants have either disenrolled from the program voluntarily or have been dropped from the program because they did not fulfill one or more of their eligibility requirements, often to their surprise.

MAPP is a valuable program for those individuals that have a strong understanding of the benefits available to them, but until these four barriers are addressed, consumers will be unable to take full advantage of the program. These consumers too often fall through the cracks in an already overly complex system of local, state and federal benefits. If these barriers are addressed, it is possible that MAPP could begin to fill these cracks and truly offer people with disabilities an equal opportunity to work.

VII. Health and Employment Counseling (HEC)

In the first year of the Medicaid Purchase Plan (MAPP) evaluation it was discovered that a large number of MAPP participants reported $0 in earned income, but were not enrolled in the Health and Employment Counseling (HEC) program. In order to be eligible for MAPP an individual is supposed to be working or enrolled in HEC. The high number of $0 wage earners not enrolled in HEC raised concerns about the efficacy of the program. As this pattern persisted into the second and third years of the program, the Center for Delivery Systems Development (CDSD) in conjunction with APS Healthcare, Inc. were able to identify several program issues that were contributing to the low utilization of HEC. These issues included:

- HEC screeners had full-time duties with their employers and did not have a strong identification with the program.
- Many economic support (ES) workers used HEC screeners as substitute "MAPP staff" because they did not know who to contact with MAPP questions. This took time away from the screeners' HEC responsibilities and limited their effectiveness performing HEC screens.
- Insubstantial and ineffective marketing support for MAPP or HEC, and
- Limited outreach to the disability community

In addition, the majority of the screeners had only a cursory understanding of benefits analysis and benefits planning for people with disabilities. Also, as unpaid assistants, the screeners had not been asked to serve consumers that were not clients of their agencies or to engage in HEC program outreach.

As a result of these early findings, CDSD took a number of steps to improve the effectiveness of HEC in 2002-2003. Seven new .2 FTE Regional HEC Screeners were hired and a Statewide HEC Coordinator employed by Employment Resources, Inc. (ERI) was assigned. The initial HEC screeners were allowed to continue to participate in the HEC screening process in year two, acting as HEC liaisons. Unlike many of the initial HEC screeners, all of the new Regional Screeners have experience with disability benefits issues, benefits analysis and counseling, service and supports available to disabled consumers, and familiarity with disability employment barriers.

A considerable amount of effort was also directed toward improving outreach for HEC in 2002. ERI staff presented information on HEC and MAPP to new Pathways to Independence Benefits Counselors and Family Care Disability Benefits Specialists during a nine day benefits counseling training in February 2002. Outreach was also conducted through the Bureau of Community Mental Health's monthly teleconference to the Wisconsin Public Psychiatry Network on January 24, 2002. In most cases, the HEC screeners reported having difficulty finding the necessary time to promote HEC because they were kept busy answering general questions about MAPP.

Despite the best efforts of the State and the HEC Screeners, HEC continued to suffer from many of the same problems that were present in the first year of MAPP

implementation. Most notably, underutilization. Earned income figures reported in CARES suggest that HEC continues to be severely underutilized. As of December 2003, 5,605 people were enrolled in MAPP, with 2,758 reporting earnings under $100 per month. Over 24% (667) of these low wage earners reported no earnings at all. At the same time, only 284 MAPP participants had entered the program via HEC[56]. This finding suggests that there are many MAPP participants who could benefit from enrollment in HEC, but for various reasons have not made it into the program.

CDSD continued to be concerned that HEC was not meeting its full potential, and directed APS Healthcare, Inc. as part of the current MAPP evaluation to investigate the underutilization of HEC, as well as other unresolved issues remaining from the initial years of the buy-in program. To accomplish this task, the evaluation team developed the following evaluation protocol:

1. Using input from previous HEC evaluation efforts, feedback from CDSD staff and suggestions from Employment Resources, Inc. (ERI), draft a series of in-person interview questions to be administered statewide to the seven HEC Regional Screeners.
2. Conduct in-person interviews with each HEC Regional Screener using these questions as a framework for discussion, while allowing for additional comments and feedback.
3. Use the results from the individual interviews to construct a list of key issues related to HEC utilization that could be addressed at the HEC Screener Quarterly Meeting held in June of 2004.
4. Discuss the key issues with all HEC Screeners during their June 2004 quarterly meeting, focusing specifically on resolutions and recommendations.
5. Use the information gathered during the individual screener interviews, as well as the quarterly meeting focus group, to draft a preliminary report to CDSD detailing the conclusions and recommendations of the HEC Screeners.
6. Use the conclusions and recommendations discussed in the preliminary report to CDSD, including CDSD feedback, to develop two brief surveys to be administered to all current and past HEC participants, and all current $0 wage earners (possibly in 2005).
7. Administer each survey, analyze the results and report the findings to CDSD, focusing specifically on recommendations for increasing the utilization of HEC among potential (and possibly existing) MAPP participants (possibly in 2005).

To date, items one through five above have been completed. The following discussion details the findings of the individual HEC Screener interviews and the HEC Quarterly Meeting focus group, including conclusions and recommendations to address employment barriers for MAPP participants, reduce administrative barriers to MAPP and HEC enrollment, and encourage HEC enrollment among new buy-in participants.

[56] As a work incentive program, MAPP requires that an individual either be working or enrolled in HEC and actively seeking employment before they can enroll in the program. The high number of people who report earning $0 in wages and are not enrolled in HEC gives the impression that this enrollment requirement is not being enforced.

Findings

The following discussion lists questions that were addressed during the HEC Screener interviews conducted between May 12 and June 22, 2004. A brief summary of the HEC Screener conclusions follows each question.

1. What do you think is happening with the MAPP participants who are not working and who are not enrolled in HEC? For example, are they engaged in work activity that does not report wages (i.e., in kind) or have they not been flagged for HEC by the county for some other reason?

   The consensus among HEC Screeners is that most people who report $0 earnings, but who are not enrolled in HEC, are engaged in in-kind work. This finding confirms CDSD and APS expectations. It was also suggested that some MAPP participants who report in-kind earnings are simply doing enough to stay eligible in the program. Similarly, the screeners also commented that many ES workers have very large caseloads, which influence them to "find" in-kind employment for their clients so that the clients can enroll in MAPP. It was estimated by the HEC screeners that approximately half of the ES workers embrace the notion of in-kind employment, while the remaining half still consider allowing in-kind employment an abuse of the Medicaid system.

2. Can you identify any barriers that keep people from enrolling in HEC? Are the barriers systemic or individual in nature?

   Barriers to obtaining, maintaining and increasing employment fall into two broad categories, individual and systemic. Individual barriers cited by the screeners included level of functioning/disability, fear of losing Medicaid healthcare coverage among program participants if they choose to work, and dependence on medications, specifically among participants with mental illness.

   Fear of losing Medicaid healthcare coverage as a result of working is very limited, and generally subsides quickly once enrolled in the program. Limited or no access to medications poses a greater barrier to HEC enrollment. Many potential HEC enrollees require numerous medications to function, and without them, they often have difficulty seeking out additional assistance or alternative programs like HEC and MAPP. This is especially true among individuals with mental illness. Without proper medications, many of these individuals cannot actively participate in the community. Although HEC does provide an access point to receive medications through MAPP, it appears as though many people still have difficulty reaching the point where they can enroll in the program.

   Systemic barriers are by far the most serious barriers to accessing HEC/MAPP. These barriers can be broken down into three distinct groups: program specific barriers, disability resource barriers and general societal barriers.

MAPP itself presents several barriers to enrollment in HEC/MAPP. Limited outreach and education regarding HEC/MAPP among potential consumers, family members, counties and case workers has led to a general lack of understanding of HEC/MAPP, including the program's requirements and benefits.

MAPP policies and procedures also serve as barriers to enrollment. The current premium formula, which "taxes" unearned income more heavily than earned income is seen by all HEC Screeners as a significant barrier to enrollment. The trouble with the existing formula is highlighted by two participant groups, those with high SSDI payments and those with mental illness. Disabled individuals with high SSDI payments are most likely to have the necessary skills/knowledge to be able to engage in substantial work; however, their high SSDI payments result in a premium that nullifies any incentive to work at a substantial level. Among the mentally ill, the ability to deduct impairment-related work expenses (IRWEs) and medical remedial expenses (MRE) within the premium formula is of little use. In many cases, medications are the only medical expense that people with mental illness need to function, and since medications are covered under the Medicaid benefit they are not deductible, leaving no (or few) other deductions and resulting in a relatively high premium. If a person with a mental illness cannot afford the premium, they may lose their MAPP eligibility and in turn their medication coverage, which then makes it very difficult to maintain employment. This cycle was noted by several of the HEC Screeners.

Lastly, although MAPP is a work incentive program, and HEC does provide the opportunity to outline employment goals, the program does not offer any vocational services or supports besides Medicaid coverage. There are no built-in supports or funding to help HEC participants acquire, maintain or increase employment. Based on screener feedback, it appears that a lack of coordination with existing vocational services, or the development of new vocational services accessed directly through MAPP, is a significant barrier to enrollment and utilization of the program.

In addition to these barriers, the HEC Screeners also pointed out several weaknesses in the current disability service delivery system in Wisconsin. The overall complexity of the system of SSI, SSDI, Medicaid and Medicare services often discourages people before they ever get enrolled in one of these programs. In addition, waiting lists for disability and employment services, such as those provided by the Division of Vocational Rehabilitation (DVR), as well as waiting lists for assistive services and personal care services, especially for those that want to work at a more substantial level, serve as barriers to enrollment. Limited transportation opportunities also cause difficulty for many people with disabilities, and there is no effective network for consumer complaints outside of the county.

Equally as important are difficulties with Economic Support (ES) workers at the county level. ES workers typically have very large caseloads, and high turnover. When combined with the relatively small nature of the MAPP program within Wisconsin Medicaid, ES workers do not typically devote a great deal of attention to potential MAPP cases. Without direct pressure from the State, most ES workers have very little incentive to fully understand or utilize MAPP.

General societal barriers include lack of Americans with Disabilities Act (ADA) compliance, the slowing of the economy and related reductions in overall job opportunities, lack of "worthwhile" jobs for people with disabilities, few incentives for businesses to hire people with disabilities, and general community attitudes and pre-conceptions about the abilities of people with disabilities.

3. Could HEC participants benefit from some type of coordinated employment planning assistance?

   In general, the HEC Screeners believe that there are people on MAPP who could benefit from some type of coordinated employment service(s). However, they also realize that the funding and staffing to provide these services does not exist at this time. The screeners are most concerned about anyone on MAPP who is on a DVR waiting list, or does not wish to return to DVR. Ideally, MAPP would be a self-contained work incentive and employment services program, walking the consumer through the process from start to finish and offering assistance with employment goals or questions at anytime after enrollment in the program.

4. Do you think there are more MAPP participants who should have been directed to HEC (i.e., people who do not report working or who report working very little) that were not?

   Following-up with the comments from above regarding the ES workers, several of the HEC Screeners feel that many ES workers simply miss MAPP completely. For example, a common response to a new consumer might be, "Oh, you earn how much? You won't qualify for Medicaid. Come back later if anything changes." In addition, several ES workers "find" in-kind work that the consumer is currently doing which qualifies them for MAPP and bypasses HEC, even if the consumer would like to work more and could use HEC in that regard. Many new program participants start out doing in-kind work but stop over time. This group may not report that they are no longer working because there is no incentive to do so. Others may agree to do in-kind work, but never begin working.

5. Can you think of things that might encourage more people to use HEC?

   Removing or reducing any of the barriers listed in question two above would encourage more people to use HEC. By far the simplest way to encourage more participation in HEC would be to require some type of earnings or tax liability verification. Verifying income through tax liability would require that most

program participants currently engaged in in-kind work access HEC as a means to stay eligible for MAPP while they looked for employment that would provide countable earnings or incur a tax liability. Other suggestions included additional funding or support so that the HEC Screeners or another qualified benefits specialist could provide thorough benefits counseling to all potential new enrollees. Several screeners also pointed out that additional marketing materials located in county human service offices, financial service offices, DVR offices and hospitals may draw more people to HEC. Positive images of active workers with disabilities were recommended to encourage people to seek out more information on HEC/MAPP. At least two screeners pointed out that existing HEC/MAPP marketing materials do not accurately convey the goals of the programs, which often discourages people from participating in the program.

6. Do you think there are more MAPP participants who could benefit from employment planning services like HEC if they were available?

   Essentially, anyone who would like to work more could benefit from additional employment services; specifically, assistance with job training, interview skills, or benefits counseling. Although these services are also available through DVR, not all MAPP participants can or want to access DVR services. MAPP participants who are eligible for raises or increased hours at their current job could benefit from continued benefits counseling, some of which is done informally by the HEC Screeners.

7. How much has HEC been used as an outreach tool for MAPP and should that role continue, be expanded or diminished?

   To date, HEC has been the only consistent outreach tool for MAPP. The HEC Screeners often conduct formal and informal meetings with local county staff to inform them about HEC/MAPP. These meetings are either at the county's request or as part of the screeners' routine administrative activities. The screeners all feel very strongly that some form of outreach is necessary and that outreach should be expanded if possible.

   Outreach seems to be most effective with consumers, and less so with county workers. To address this difference, several screeners suggested outreach or training directly from state staff to the counties so that the trainings would carry more weight at the local level. However, most screeners would like to continue providing outreach as part of their HEC responsibilities, especially if funding is available to make HEC/MAPP outreach a separate activity within the HEC contract. All screeners realize that additional funding is problematic. There was also some confusion over whether or not the original HEC funding could be used to conduct outreach. Some screeners commented that they were told by the State not to use their HEC funding to conduct outreach, and that all HEC funding was to go directly to the consumer screening process.

Screener Recommendations

As a follow-up to the individual in-person interview findings, the following five questions were addressed at the June 22, 2004 HEC Quarterly Meeting held at ERI in Madison. All seven HEC Screeners were present for the meeting and each provided substantial feedback. The following lists of recommendations are grouped within these five questions; however, several recommendations also come directly from the results of the in-person interviews discussed above.

1. What would be the most effective approach to improve outreach at the county and participant levels?

    - Build outreach activities into the existing HEC contract.
    - Provide state training and outreach to county workers. HEC Screeners carry very little weight within county human service departments.
    - Regardless of who organizes the outreach or training, in-person trainings are the most effective. Letters, memos and computer trainings get ignored or misplaced too easily.
    - Have a presence at the Statewide Resource Conference (booth and/or general session on HEC/MAPP).
    - Train a group of ES workers throughout the state, specifically in larger counties, to be MAPP specialists.
    - Send MAPP specific operations memos once or twice per year to the counties to keep MAPP fresh in the workers' minds.
    - Piggy-back any MAPP training with more general ES worker training provided by the State.
    - Provide more general CARES training for ES workers and the HEC Screeners, while including information on MAPP eligibility and enrollment.
    - Add MAPP information to the SSA/Ticket mailings.
    - Add MAPP information to the DVR/Ticket mailings.
    - Create and distribute better MAPP informational materials, such as brochures, flyers, posters, etc. Specifically, change the existing MAPP Consumer Guide and HEC Consumer Guide cover pictures to more accurately depict a working disabled population, and simplify the eligibility and benefits discussions.
    - Send congratulation letters to all new enrollees to highlight MAPP benefits and other community resources so that the participants can take full advantage of the program.
    - Inform all of the Benefits Planning, Assistance and Outreach (BPA&Os) locations about MAPP.

2. How would you restructure the current premium formula so that it is more equitable across all MAPP participants?

    - Treat earned and unearned income equally, summing the total adjusted wages and then taking a percentage (3% or 5%, etc.) of the total.
    - Establish a minimum premium to eliminate or reduce the need for very high premiums among some program participants.

- Treat unearned income differently so that people with high SSDI are not penalized. Several screeners commented that this group could be the most successful if they weren't forced to pay such high premiums.
- For people with mental illness provide automatic Medicaid to pay for medications if the person makes over $1,200 per month.
- Allow participants to earn up to 100% of poverty plus up to their $810 substantial gainful activity (SGA) with no premium, and then start premiums based on a tiered system.
- Allow people with SSDI to earn the same $27,000 or more afforded to SSI recipients under 1619b waiver coverage without taking away their MA.
- Ignore unearned income for one year if the participant earns at SGA as an incentive to work more. If at 12 months they are not earning at SGA or near SGA (percentage to be determined) then they pay a premium.
- Designate someone, preferably at the county level, to track each person's employment and earnings progress.

3. What are the greatest barriers to obtaining employment? What are the greatest barriers to increasing employment? Are they the same or different? (results provided as recommendations)

    - Modify the premium structure as discussed in number two above.
    - Increase communication and cooperation with existing vocational services at the local level.
    - Provide vocational services directly as part of HEC or MAPP.
    - Provide additional outreach to county workers, consumers, family members and other local disability care workers. Use this educational outreach to create familiarity with MAPP and its benefits among these groups.
    - Change the MAPP/HEC promotional materials to reflect people with disabilities who are active and productive in the community. Emphasize the positive aspects of MAPP through the promotional materials.
    - Provide state-level direction to the county ES workers regarding the use of MAPP.
    - Assist with setting-up transportation networks or services for MAPP participants.
    - Provide a barrier and complaint hotline that is staffed by someone outside of the counties, possibly a state employee.
    - Work with larger counties to assign one or two MAPP specialists among each county's ES workers.
    - Provide links to local benefits counselors for MAPP participants.

4. What changes or additions to HEC or MAPP do you feel would most assist people with obtaining greater employment? (Coordinated employment services for those earning little or nothing, or those that would like to increase their work.)

    - (See Recommendations in numbers one through three above)

- Provide employment training classes and make them mandatory for first time MAPP enrollees.
- Provide benefits counseling as part of MAPP.

5. How many people do you estimate are holding their earnings down to stay eligible? How many people are holding their earnings down to avoid a large premium increase?

    - An estimated 10% of MAPP participants earn at a level that might threaten their eligibility, and possibly 25% (there was wide variation on this figure among the screeners) limit their earnings to avoid the "premium cliff" where their premium becomes prohibitively higher.
    - (See suggested recommendations under number two to address this issue.)

It is very clear that HEC is underutilized; however, it is equally as apparent that HEC has been very helpful for those who have accessed the program. The HEC screeners provide HEC enrollees with basic MAPP information, informal and formal benefits counseling, links to DVR and area job centers, and the development of job goals. In addition, MAPP has received invaluable outreach and community/provider education through HEC, neither of which can be found elsewhere in MAPP.

The problem with utilization is directly related to several structural barriers built into MAPP, most notably the acceptance of in-kind income to meet the work requirement; the lack of resources to conduct thorough verification of employment among program participants; and the lack of resources to provide vocational services as part of MAPP. Until the basic structure of MAPP is redesigned to funnel all appropriate cases into HEC, including those individuals who are working, but would like to work more, it is likely that HEC will continue to be underutilized.

VIII. Targeted Analyses

Chronic Illness and Disability Payment System (CDPS)

The CDPS tool has been used in each of the previous three MAPP Annual Reports to determine illness burden among MAPP participants in an effort to create a non-MAPP Medicaid eligible comparison group with similar levels of need for testing the cost-effectiveness of MAPP. However, the CDPS has never been analyzed exclusively to provide an idea of level or type of disability among the MAPP participants. Recently, other states with Medicaid buy-in programs have been using the CDPS, or a modified version of CDPS, as a tool to determine disability type. Determining disability type is particularly important for a work incentive program such as MAPP in order to determine if the program is more effective for individuals with some disabilities than others. Determining disability type will allow the evaluation team to stratify analysis results and determine where the program is most effective.

Previously, two attempts had been made to obtain disability determination data from the Wisconsin Disability Determination Bureau (DDB). The first attempt in 2001 yielded a small sample of respondents with current disability determinations, largely due to the relatively low enrollment in MAPP at that time. A second attempt in early 2002 yielded considerably more matches between current (March 2002) MAPP participants and their disability determinations.[57] However, there remained a large percentage of program participants for whom a disability determination could not be obtained. Because complete DDB data are not readily available, the CDPS has been chosen as an alternative means of determining disability type.

Using standard ICD-9 diagnosis codes, the CDPS groups program participants into 18 primary chronic condition categories.[58] State fiscal year (SFY) 2003 and 2004 data were used to obtain the CDPS results. The two most recent SFYs were used to examine the possibility of disability related trends in the MAPP population.

The majority of MAPP participants in each year fell within multiple CDPS diagnosis groups. For SFY 2003, 12% of the MAPP population did not fall within one of the CDPS chronic condition categories, while 19% fell into one category and over 68% fell into multiple categories. In comparison, 11% of the SFY 2004 participants did not have a CDPS chronic condition, while 18% qualified for one CDPS category. Over 71% of the SFY 2004 participants fell into more than one CDPS category.

The most common chronic condition among MAPP participants in both SFY 2003 and SFY 2004 was “psychiatric”, which could include illnesses such as schizophrenia, bipolar effective disorder, panic disorders, phobias or depression, among others. Over 47% of MAPP participants in each year fell into this category. Cardiovascular related conditions were the second most common group of conditions in both years, with skeletal and connective, nervous system and gastrointestinal conditions rounding out the top five in each year. The following table provides a

[57] Results of the second DDB analysis were discussed in the 2003 MAPP Annual Report.

[58] The chronic condition categories for the CDPS can be found in *Attachment I* in Section X. Appendix. These categories can be rolled into broader categories or broken out into sub-categories based on intensity of the chronic condition.

complete listing of the prevalence of chronic conditions among MAPP participants in SFYs 2003 and 2004.

Prevalence of Chronic Conditions Among MAPP Participants Based on CDPS Findings

	SFY 2003		SFY 2004	
	N=5,675	*Percent*	*N=7,977*	*Percent*
Psychiatric	2,666	47.0%	3,761	47.1%
Cardiovascular	2,132	37.6%	3,268	41.0%
Skeletal and Connective	1,718	30.3%	2,593	32.5%
Nervous System	1,580	27.8%	2,489	31.2%
Gastrointestinal	1,363	24.0%	2,057	25.8%
Pulmonary	1,217	21.4%	1,863	23.4%
Diabetes	1,066	18.8%	1,638	20.5%
Renal	743	13.1%	1,148	14.4%
Skin	662	11.7%	983	12.3%
Eye	581	10.2%	985	12.3%
Subtance Abuse	453	8.0%	614	7.7%
Metabolic	423	7.5%	624	7.8%
Developmental Disability	417	7.3%	522	6.5%
Cancer	319	5.6%	482	6.0%
Genital	239	4.2%	259	3.2%
Cerebrovascular	215	3.8%	356	4.5%
Infectious Disease	205	3.6%	342	4.3%
Hematological	198	3.5%	310	3.9%
Pregnancy	27	0.5%	41	0.5%

The CDPS is a useful tool for identifying general illness categories based on actual participant health care claims data; however, the problem remains that most MAPP participants fall within multiple CDPS chronic condition categories based on their health care claims histories. Without auditing individual cases, CDPS is limited in its ability to determine which chronic condition provides the basis for the individual's disability determination. More work with the CDPS is planned for the 2005 MAPP evaluation.

Age Analysis

In early 2004, questions were raised regarding the composition of the MAPP population, particularly the age distribution of the population and any changes in the distribution that might be occurring as the program matures. Specifically, CDSD was interested in the impact on older MAPP participants if MAPP were to operate under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), as opposed to the current Balanced Budget Act of 1997 (BBA). The Ticket legislation allows for an age cap and the BBA does not. As such, CDSD wanted to examine the current characteristics of older adults enrolled in MAPP as a preliminary step in assessing the impact of such a change on the program. A preliminary analysis was conducted in April 2004 to analyze the past and current age distribution of the MAPP population, focusing on trends over time, as well as prior Medicaid status, premiums amounts, geographic distribution and earned income.

The age analysis findings revealed that the average age of a MAPP participant has remained relatively stable since program inception, increasing from 46 years to 49 years between January 1, 2001 and April 1, 2004. Through six months following automation of MAPP eligibility in CARES, new enrollees averaged almost 48 years of age. Participants over the six month period prior to the analysis in April 2004 average just over 48 years of age.

Furthermore, participants with Medicaid coverage in the month prior to their MAPP enrollment averaged over 46 years of age, while participants without prior Medicaid coverage averaged just over 49 years old. Of interest, almost 36% of program participants without prior Medicaid were 55 or older. In contrast, only 27% of participants with prior Medicaid were over 55.

Premium payers by age group appear to be very consistent with past trends among all MAPP participants. Over the three month period directly prior to the April 2004 analysis, an average of 10% of MAPP participants had been required to pay a premium, and this pattern held true among each of the age groups shown in the chart below. A slight exception is apparent among the 65 and over group, where approximately 5% were paying premiums. In addition, the average premium paid among the 65 and over group was much lower than the average premium paid by any other group.

Premium Payers by Age Group
March 2004

Premium Category	All Participants *(Ave.=$163.20)*		< 55 *(Ave.=$156.12)*		55-64 *(Ave.=$197.19)*		65 Plus *(Ave.=$115.74)*	
$0	5,436	90.31%	3,471	89.00%	1,427	91.83%	538	95.22%
$25-$50	222	3.69%	169	4.33%	37	2.38%	16	2.83%
$75-$100	83	1.38%	64	1.64%	16	1.03%	3	0.53%
$125-$200	122	2.03%	85	2.18%	33	2.12%	4	0.71%
$225-$375	99	1.64%	72	1.85%	25	1.61%	2	0.35%
$400-$875	55	0.91%	38	0.97%	15	0.97%	2	0.35%
> $875	2	0.03%	1	0.03%	1	0.06%	0	0.00%
Total	**6,019**	**100.00%**	**3,900**	**100.00%**	**1,554**	**100.00%**	**565**	**100.00%**

The distribution of MAPP participants by county appears to be relatively consistent between age groups; however, the 55 to 64 group and 65 plus group do show some counties with higher than expected MAPP enrollment. These counties are highlighted in yellow in the chart on the following page.

County Distribution of MAPP Participants by Age Group Top 10 - March 2004								
All Participants *(N=6,019)*		**< 55** *(N=3,900)*		**55 to 64** *(N=1,554)*		**65 Plus** *(N=565)*	
Dane	9.74%	Dane	10.67%	Dane	9.07%	Milwaukee	9.91%
Milwaukee	9.32%	Milwaukee	9.67%	Milwaukee	8.24%	Barron	5.66%
Kenosha	4.78%	Kenosha	4.54%	Kenosha	5.73%	Washburn	5.49%
Winnebago	4.05%	Winnebago	4.13%	Winnebago	4.31%	Grant	5.31%
Waukesha	3.36%	Waukesha	4.10%	Barron	3.35%	Dane	5.13%
LaCrosse	3.27%	LaCrosse	3.46%	LaCrosse	3.22%	Kenosha	3.89%
Marathon	2.67%	Outagamie	2.69%	Douglas	2.90%	Marathon	3.01%
Barron	2.54%	Eau Claire	2.67%	Washburn	2.90%	Winnebago	2.83%
Eau Claire	2.54%	Marathon	2.67%	Rock	2.70%	Rock	2.83%
Brown	2.26%	Brown	2.54%	Marathon	2.57%	Douglas	2.30%

The counties with higher than expected enrollment among the 65 and over participants may be investigated further during the 2005 MAPP evaluation to determine if there are other factors related to these differences or if they are solely due to chance.

Lastly, as might be expected, monthly average earned income was much lower among the 65 and over participant group than any other group. Results can be found in the table below.

Monthly Earned Income by Age Group March 2004								
Earned Income	**All Participants** *(Ave.=$243.88)*		**< 55** *(Ave.=$287.52)*		**55-64** *(Ave.=$169.94)*		**65 Plus** *(Ave.=$145.45)*	
$0	760	12.79%	420	10.90%	229	14.91%	111	20.04%
$1-$100	2,390	40.22%	1,344	34.89%	763	49.67%	283	51.08%
$101-$250	822	13.83%	576	14.95%	192	12.50%	54	9.75%
$251-$500	911	15.33%	670	17.39%	180	11.72%	61	11.01%
$501-$750	657	11.06%	522	13.55%	116	7.55%	19	3.43%
$751-$1,000	207	3.48%	167	4.34%	25	1.63%	15	2.71%
$1,001-$1,250	62	1.04%	46	1.19%	13	0.85%	3	0.54%
$1,251-$1,500	50	0.84%	39	1.01%	9	0.59%	2	0.36%
$1,501-$1,750	33	0.56%	25	0.65%	4	0.26%	4	0.72%
Over $1,750	50	0.84%	43	1.12%	5	0.33%	2	0.36%
Total	**5,942**	**100.00%**	**3,852**	**100.00%**	**1,536**	**100.00%**	**554**	**100.00%**

Currently, there are no plans to change the legislative authority of MAPP from the BBA to the TWWIIA. If this change is considered further in the future, the age analysis will be updated and enhanced to as accurately as possible predict the impact of such a change on older MAPP participants.

Tenure Analysis

Based on the Recipient Survey findings reported earlier, questions arose regarding the effect of MAPP tenure on some of the survey results. During the course of the evaluation and discussion of the survey findings, it was suggested that early MAPP enrollees may be in some ways different from more recent enrollees. As an increasing number of low income participants began to join MAPP, the composition of the varying cohorts of MAPP enrollees became an even greater topic of discussion. As a precursor to a more in-depth analysis of MAPP tenure scheduled for 2005, a preliminary examination of specific survey respondents and demographic characteristics were examined based on their initial enrollment dates in MAPP.

All survey respondents, as well as all MAPP participants at the time of the original survey analysis (December 2003), were divided into two mutually exclusive groups. The first group included all enrollees who began their MAPP participation at least 24 months prior to the mailing of the final recipient survey batch in October 2003 (i.e., prior to October 31, 2001). The second group contained all enrollees who enrolled in MAPP after October 31, 2001. These dates were selected so that each respondent in the analysis could have potentially responded to each of the Recipient Surveys, Initial, 6-Month, 12-Month and 24-Month.

Several between group comparisons were analyzed, yet few relationships were evident. The items tested included:

1. Monthly earned income from CARES
2. Monthly earned income self-reported on the survey
3. Annual earned income self-reported on the survey

Several survey questions were also analyzed between groups. They included:

- Do you fully understand your financial options under MAPP? (Questions 1K Initial and 2L Follow-up)
- Now that you have enrolled, how afraid are you that you will lose your Medicaid health insurance because you work or may work? (Questions 2 Initial and 4 Follow-up)
- How many hours do you work in a typical week? (Questions 11 Initial and 10 Follow-up)[59]
- How satisfied are you with your job? (Questions 24 Initial and 25 Follow-up)
- How much physical and emotional support and help for day-to-day activities do you now receive from Medical personnel, including social service workers, case managers, in-home workers, and other caregivers, including charities? (Questions 41 Initial and 42 Follow-up)
- Would you recommend MAPP to other people with disabilities? (Questions 70 Initial and 75 Follow-up)
- Overall how satisfied are you with MAPP. (Questions 72 Initial and 77 Follow-up)

[59] Mean differences were not tested for this question because the response categories do lend themselves to this type of testing (categorical responses); however, the frequencies for each group were visually reviewed for any obvious differences.

Findings from these analyses show few significant differences between the early enrollees and their later counterparts. However, earnings did vary between these cohorts across several of the survey respondent groups. Among all enrollees, regardless of survey participation, the early enrollees reported significantly higher average monthly earned income than the enrollees with later enrollment dates, $361 versus $261 per month. This pattern held true among the Initial Survey respondents as well, where the early enrollees averaged $359 per month and the later enrollees averaged $272 per month. The same relationship was found among the 12-Month respondents; however the difference was even greater. Early 12-Month enrollees reported an average monthly earned income of $305, as compared to only $198 for the later 12-Month respondents. Lastly, the early 6-Month respondents reported significantly greater annual income ($4,790) than the later enrollees ($2,786).

These findings reinforce what was suspected about the most recent wave of MAPP enrollees, that they are generally earning less than the initial enrollees in the program. This could be because county workers and potential applicants are becoming more aware of the in-kind eligibility option, or as MAPP awareness continues to increase more low wage earners have realized that they could qualify for MAPP and are applying and becoming eligible. This phenomenon requires significantly more analysis in 2005 to fully understand the shift in participant cohorts over time and to determine what other participant characteristics have changed as the program has matured. The 2005 analysis will also examine the impact that these participant changes may have on MAPP and if the program is more effective for a particular group of participants. In addition, tenure will be defined in some manner that accounts for both initial enrollment (exposure) to MAPP, as well as length of actual participation in the program (i.e., number of months of MAPP eligibility since initial enrollment) to help determine the impact of MAPP on these differences.

Highest Premium Payer Analysis

As noted earlier, respondents who are required to pay a premium to participate in MAPP go through a relatively complex formula to determine their raw premium liability, which is then placed in $25 rate bands and rounded down to the nearest $25 increment to determine actual premium liability. Any premium liability calculated above $1,000 is paid at its actual level, and in most months one or two program participants pay a premium greater than $1,000.

In March 2004, a cursory analysis was done to investigate why these individuals continue to pay such high premiums. Generally speaking, these individuals have rather high SSDI income, typically in the $1,500 range, and have small family sizes, typically one or two individuals, which greatly reduces the income level under which they would not be liable to pay any premium.

A more detailed analysis of premium payers with very high premiums, possibly above $500 per month, may be revisited in 2005. At a minimum, the few participants paying over $1,000 may be analyzed to determine why such high premiums are cost-effective for these participants, or whether or not they actually are cost-effective based on their health care utilization through Medicaid.

IX. Future Analyses

Based on the findings from year four of the MAPP evaluation, CDSD, in conjunction with APS, has developed a detailed list of 2005 activities and analyses to be conducted as part of the year five MAPP evaluation. These activities are designed to strengthen the findings presented in this report, but more importantly, to fill gaps where specific program and policy questions remain unanswered. The evaluators will examine the following topics and possibly others as time and resources allow.

- Further examine self-employment and in-kind income among MAPP consumers.
- Examine MAPP enrollee tenure, including a profile of the length of participation in the MAPP program.
- Conduct a cost comparison of enrollees using HIPP.
- Conduct analyses to examine the potential impact of Medicare Part D on the MAPP program and MAPP consumers.

X. Appendix

Attachment A: Premium Schedule

PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The Premium is:	Sum of Adjusted countable Unearned and Adjusted Earned Income		The Premium is:
From	**To**	**Premium**	**From**	**To**	**Premium**
$0	$10.00	$0.00	500.01	525.00	500.00
10.01	25.00	$0.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.01	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
450.01	475.00	450.00	9950.01	975.00	950.00
475.01	500.00	475.00	975.01	1,000.00	975.00

Note: If the sum of Adjusted Countable Unearned Income and Adjusted Earned Income is greater than $1,000.00 per month, the premium shall be equal to the exact dollar amount of this sum.

Attachment B: Eligibility Trends for MAPP Participants

ELIGIBILITY TRENDS FOR MAPP ENROLLEES

Data as of October 20, 2004

MONTH OF YEAR	NEW MAPP ENROLLEES[1]	# WITH ELIGIBILITY PRIOR MONTH[2]	% WITH ELIGIBILITY PRIOR MONTH[2]	# WITH ANY PRIOR ELIGIBILITY[3]	% WITH ANY PRIOR ELIGIBILITY	# WITH POST MAPP ELIGIBILITY[4]	MAPP DISENROLLMENTS[5]	MAPP NET NEW ENROLLEES[6]
January 2000	32	7	21.9%	24	75.0%	13	0	32
February 2000	14	5	35.7%	10	71.4%	8	1	13
March 2000	40	20	50.0%	34	85.0%	21	0	40
April 2000	40	17	42.5%	34	85.0%	24	0	40
May 2000	61	32	52.5%	52	85.2%	26	3	58
June 2000	113	67	59.3%	96	85.0%	48	2	111
July 2000	133	81	60.9%	117	88.0%	61	3	130
August 2000	107	59	55.1%	93	86.9%	54	4	103
September 2000	104	53	51.0%	91	87.5%	49	6	98
October 2000	124	72	58.1%	108	87.1%	57	8	116
November 2000	116	76	65.5%	97	83.6%	46	9	107
December 2000	131	106	80.9%	120	91.6%	54	14	117
January 2001	159	88	55.3%	135	84.9%	65	12	147
February 2001	95	58	61.1%	81	85.3%	40	9	86
March 2001	99	62	62.6%	86	86.9%	40	14	85
April 2001	76	47	61.8%	67	88.2%	31	16	60
May 2001	85	56	65.9%	78	91.8%	33	20	65
June 2001	78	49	62.8%	62	79.5%	34	22	56
July 2001	80	56	70.0%	71	88.8%	26	15	65
August 2001	76	44	57.9%	66	86.8%	31	11	65
September 2001	92	58	63.0%	80	87.0%	29	23	69
October 2001	80	43	53.8%	68	85.0%	29	26	54
November 2001	94	56	59.6%	82	87.2%	39	21	73
December 2001	80	46	57.5%	65	81.3%	30	20	60
January 2002	185	115	62.2%	158	85.4%	60	27	158
February 2002	293	225	76.8%	263	89.8%	75	19	274
March 2002	241	156	64.7%	211	87.6%	78	40	201
April 2002	230	149	64.8%	194	84.3%	53	34	196
May 2002	243	155	63.8%	202	83.1%	54	45	198
June 2002	235	150	63.8%	206	87.7%	87	51	184
July 2002	264	173	65.5%	220	83.3%	78	63	201
August 2002	207	127	61.4%	173	83.6%	64	48	159
September 2002	211	135	64.0%	184	87.2%	60	38	173
October 2002	233	143	61.4%	199	85.4%	83	47	186
November 2002	196	123	62.8%	171	87.2%	60	54	142
December 2002	200	134	67.0%	173	86.5%	57	52	148
January 2003	285	188	66.0%	253	88.8%	77	81	204
February 2003	212	133	62.7%	179	84.4%	47	65	147
March 2003	241	161	66.8%	202	83.8%	59	70	171
April 2003	219	137	62.6%	188	85.8%	44	82	137
May 2003	201	126	62.7%	172	85.6%	47	57	144
June 2003	222	145	65.3%	191	86.0%	46	64	158
July 2003	237	142	59.9%	194	81.9%	56	61	176
August 2003	229	145	63.3%	193	84.3%	52	100	129
September 2003	247	143	57.9%	205	83.0%	44	92	155
October 2003	221	142	64.3%	182	82.4%	49	91	130
November 2003	239	134	56.1%	191	79.9%	41	74	165
December 2003	218	132	60.6%	177	81.2%	41	119	99
January 2004	280	194	69.3%	256	91.4%	45	98	182
February 2004	305	203	66.6%	265	86.9%	31	124	181
March 2004	220	133	60.5%	184	83.6%	23	104	116
April 2004	259	172	66.4%	234	90.3%	27	95	164
May 2004	275	198	72.0%	235	85.5%	28	107	168
June 2004	245	164	66.9%	209	85.3%	16	123	122
July 2004	247	184	74.5%	221	89.5%	15	132	115
Sums:	**9449**	**6019**	**63.7%**	**8102**	**85.7%**	**2485***	**2516**	**N/A**

[1] The minimum MAPP enrollment date for an individual

[2] Individuals having a non-MAPP eligibility segment with an end date between the minimum MAPP start date and 31 days prior to the minimum MAPP start date

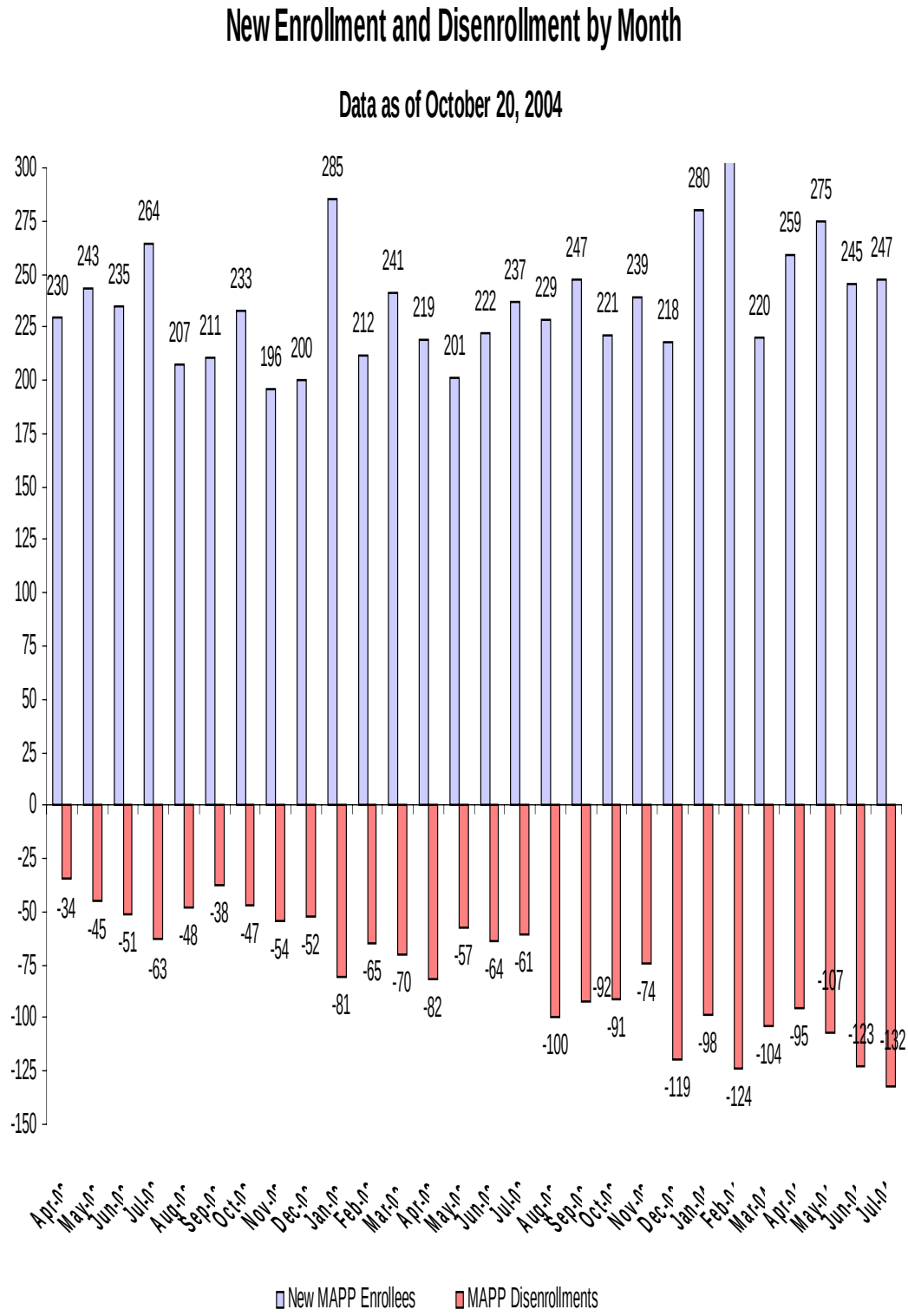
[3] Individuals having a non-MAPP eligibility segment with an end date before the minimum MAPP start date

[4] Individuals having a non-MAPP eligibility segment beginning after their minimum MAPP start date. The assigned month represents the first month of the non-MAPP eligibility segment.

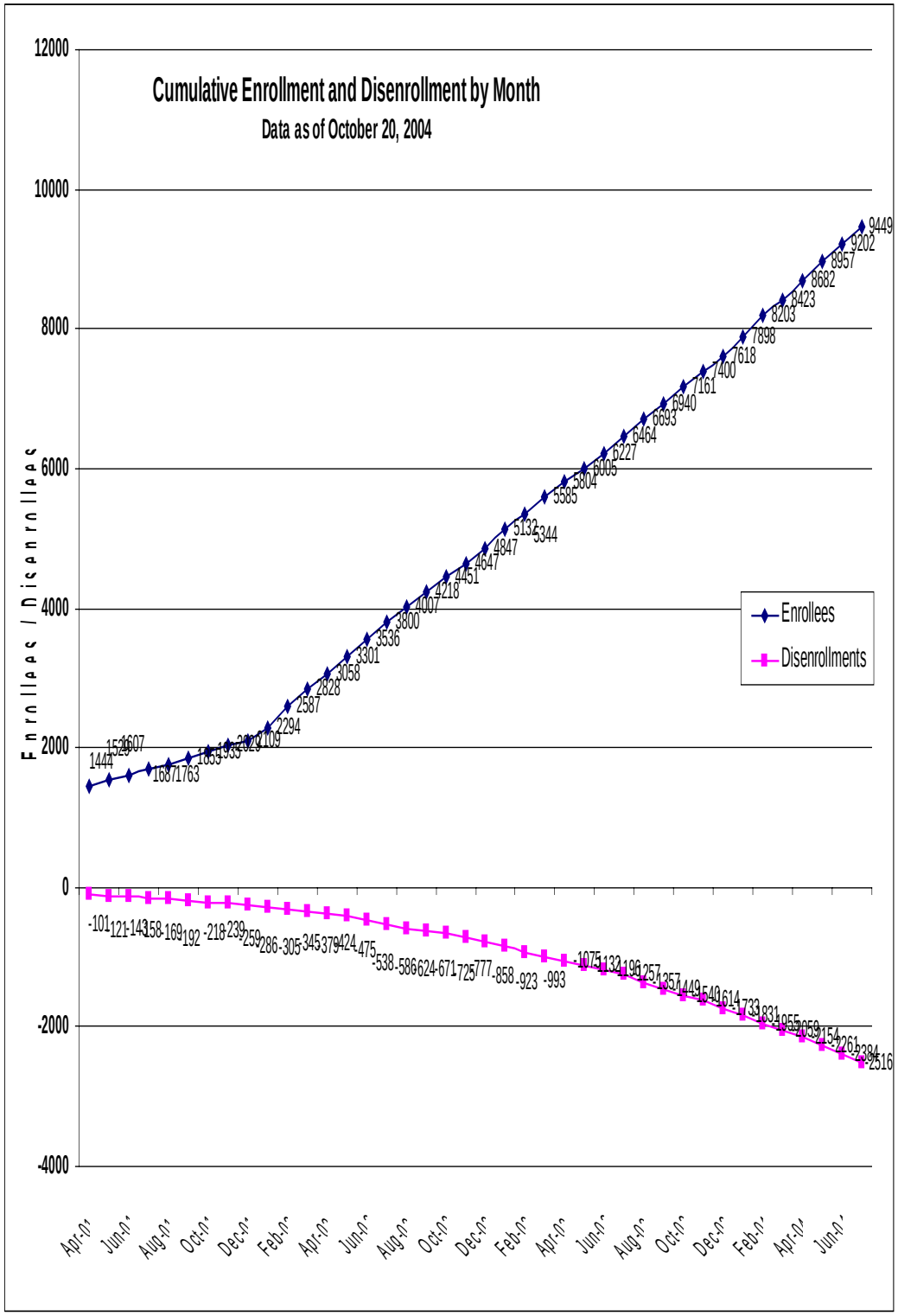
[5] The maximum MAPP end date for an individual (most recent disenrollment). Disenrollees include all MAPP enrollees that have not re-enrolled in MAPP as of the month of this report. Data is not provided for the most recent quarter because enrollees may have new eligibility segments that are not yet captured in the data. Those individuals will be included in the following quarter.

[6] New MAPP enrollees minus MAPP disenrollees for each month

Attachment C: New Enrollment and Disenrollment by Month



Attachment D: Cumulative Enrollment vs. Current Enrollment by Month



Attachment E: MAPP Enrollment by Premium Status

MAPP Enrollment by Premium Status
July, 2002 – October, 2004

Benefit Month	Participants With Premium Med Stat Code	Participants Without Premium Med Stat Code	Total Enrollment	% of Total With Premium Med Stat Codes
July 2002	420	2,666	3,086	14%
August 2002	430	2,784	3,214	13%
September 2002	435	2,933	3,368	13%
October 2002	444	3,106	3,550	13%
November 2002	447	3,265	3,712	12%
December 2002	467	3,387	3,854	12%
January 2003	518	3,572	4,090	13%
February 2003	494	3,701	4,195	12%
March 2003	515	3,845	4,360	12%
April 2003	507	4,020	4,527	11%
May 2003	497	4,141	4,638	11%
June 2003	500	4,294	4,794	10%
July 2003	519	4,438	4,957	10%
August 2003	545	4,589	5,134	11%
September 2003	547	4,729	5,276	10%
October 2003	547	4,862	5,409	10%
November 2003	549	5,010	5,559	10%
December 2003	565	5,143	5,708	10%
January 2004	605	5,290	5,895	10%
February 2004	605	5,504	6,109	10%
March 2004	597	5,623	6,220	10%
April 2004	555	5,836	6,391	9%
May 2004	564	6,031	6,595	9%
June 2004	586	6,201	6,787	9%
July 2004	586	6,360	6,946	9%
August 2004	597	6,504	7,101	9%
September 2004	641	6,582	7,223	9%
October 2004	645	6,682	7,327	9%

Attachment F: IRWE and MRE Examples

Examples of Impairment Related Work Expenses (IRWE):

- Attendant care services (at work, for transportation, other)
- Diagnostic procedures
- Durable medical equipment (plus installation, maintenance, and associated repair costs)
- Essential non-medical appliances and devices (electric air cleaner, etc.)
- Exterior home modifications that allow access to the street or to transportation (ramps, railings, pathways, etc.)
- Interior home modifications which create a work to accommodate impairment (enlargement of doorway, etc.)
- Interpreter (at workplace)
- Job Coach
- Medical devices
- Measuring instruments
- Mileage allowance (to and from work)
- Modified audio/visual equipment (enlarged monitor, speech activated computer, etc.)
- Pacemakers
- Physical therapy
- Prostheses
- Reading aids
- Regularly prescribed medical treatment or therapy and physician's fees associated with this treatment
- Respirators
- Routine prescription drugs
- Special work tools
- Traction equipment, braces
- Typing aids
- Vehicle modification (plus installation, maintenance, and associated repair costs)
- Wheelchairs
- Work animal and associated costs (plus food, maintenance, and veterinary services)
- Workspace modifications (adjustable desk, etc.)
- Work subsidy (increased supervision, etc.)

Examples of Medical Remedial Expenses

- Abdominal supports; Back supports
- Acupuncture
- Artificial teeth, eyes, limbs
- Attendant care (at workplace or other)
- Audio/visual equipment, such as screen magnifiers
- Automobile or van modification
- Automobile modified equipment; Autoette
- Bathtub/Shower accessibility modifications and
- related adaptive hardware
- Bed pads; Bed boards
- Chiropractor
- Computer/desk modifications
- Convalescent home
- Diapers
- Dietician/Nutritionist Services or Information
- Elevator
- Eyeglass prescriptions
- Excess energy costs related to a medical condition
- Handrails
- Healing services
- Health institute fees
- Health spa
- Hearing aids
- Home improvements made for medical reasons: air conditioning system, bathroom on the first floor, ramps, doorway modifications, etc.
- Hydrotherapy
- Inclinator or other device for managing stairs
- Invalid chair
- Job coach
- Life-care fee (medical portion only)
- Lodging on trips to obtain medical care
- Medicaid co-payments
- Medical supplies
- Modified clothing
- Modified eating utensils
- Outstanding medical bills
- Practical/other nonprofessional nurse for med services
- Prescription drugs
- Private health insurance premiums
- Reclining chairs
- Registered nurse
- Rental of medical equipment
- Repair of special medical equipment
- Respite care
- Special mattresses
- Special plumbing fixtures
- Special telephone equipment and associated repair costs
- Special technology needs
- Transportation costs for medical visits
- Vitamin Supplements
- Wheelchair; other equipment
- Wages of guide/assistant
- Whirlpool
- Work animals and associated maintenance costs (plus food, maintenance, and veterinary services)

Attachment G: MAPP Eligibility and Premium Modifications: Medicaid Impact Estimates

Estimated Medicaid Budget Impact Based on MAPP Policy Changes
August 2nd, 2004
Data Source: June 2004 CARES Data & April 03-March 04 MEDS Data

Policy change	Participants Remaining in MAPP Based on FICA Eligibility Changes	Participants Remaining in After FICA Changes Who Pay a Premium	Participants Remaining After FICA Changes Who Do NOT Pay a Premium	NON-Premium Payers Remaining in MAPP After Implementation of $25 Minimum Premium	Participants Remaining in MAPP After FICA and/or Premium Changes [D]	Current Total Monthly Premium Revenue (N=578)	New $25 Premium Payers	New TOTAL Monthly Premium Revenue	Annual Change in MAPP Premium Revenue: + or (-)	MAPP Participants Leaving MAPP Due to FICA & Premium Changes	MAPP "Leavers" Returning To Medicaid Under Another Medicaid Eligibility Category (86% Return)	Net Medicaid Participants Lost if 86% of "Leavers" Re-enroll in Medicaid [E]	Average Annual Expenditures Per MAPP Participant April 2003-March 2004: MAPP ONLY CLAIMS [F]	Net Annual Medicaid Savings If 86% of "Leavers" Re-Enroll in Medicaid	Approximate MAPP Expenditures Based on April 2003-March 2004 Expenditures	Estimated MIG Grant Revenue AND Net Annual Medicaid Savings
Current MAPP Figures	**6,667**	**578**	**6,089**	**6,089**	**6,667**	**$94,318**	**N/A**	**N/A**	**$1,131,814**	**0**	**0**	**0**	**$5,936**	**N/A**	**$39,576,699.48**	**$3,957,669.95**
A) Require evidence of any FICA contributions (e.g. wage stubs, self employment tax forms)[A]	5,830	573	5,257	5,257	5,830	**$94,318**	N/A	$91,218	($37,200)	837	720	117	**$5,936**	$658,405	$34,608,093.29	**$4,119,214.20**
B) Require evidence of FICA contributions of $296.67 per month (e.g. wage stubs, self employment tax forms)[B]	1,960	518	1,442	1,442	1,960	**$94,318**	N/A	$67,475	($322,114)	4,707	4,048	659	**$5,936**	$3,589,728	$11,634,967.90	**$4,753,224.77**
C) Require evidence of FICA contributions of $117/month or $36/month for the self-employed.[C]	3,195	550	2,645	2,645	3,195	**$94,318**	N/A	$78,550	($189,214)	3,472	2,986	486	**$5,936**	$2,696,258	$18,966,184.92	**$4,592,876.09**
D) $25 monthly minimum premium for ALL participants	6,667	578	6,089	5,785	6,363	**$94,318**	5,785	$238,932	$1,735,365	304	262	43	**$5,936**	$1,988,384	$37,769,420.92	**$5,765,326.09**
E) $25 monthly premium for all participants currently over 150% of FPL paying $0	6,667	578	6,089 - **NOTE: 525 have income >$150% of FPL**	6,063	6,641	**$94,318**	499	$106,787	$149,625	26	23	4	**$5,936**	$171,441	$39,420,874.02	**$4,113,527.97**
F) A and D combined [i.e., any FICA contribution and $25 min premium]	5,830	573	5,257	4,994	5,567	**$94,318**	4,994	$216,072	$1,461,045	1,100	946	154	**$5,936**	$2,375,096	$33,047,760.99	**$5,679,872.49**
G) B and D combined [i.e., > $296.67 per month FICA contribution and $25 min premium]	1,960	518	1,442	1,370	1,888	**$94,318**	1,370	$101,723	$88,856	4,779	4,110	669	**$5,936**	$4,060,618	$11,206,967.29	**$5,181,314.80**
H) C and D combined [i.e., >$117 or >$36 per month and $25 min premium]	3,195	550	2,645	2,513	3,063	**$94,318**	2,513	$141,369	$564,611	3,604	3,100	505	**$5,936**	$3,559,991	$18,181,121.39	**$5,378,103.63**
I) A and E combined [i.e., any FICA contribution and $25 premiums for those over 150% FPL currently with $0 premium]	5,830	573	5,257, **NOTE: 523 have income >150% of FPL**	5,231	5,804	**$94,318**	497	$103,643	$111,900	863	742	121	**$5,936**	$829,237	$34,452,861.45	**$4,274,523.47**
J) B and E combined [i.e., > $296.67 FICA contribution and $25 premiums for those over 150% FPL currently with $0 premium]	1,960	518	1,442, **NOTE: 500 have income >150% of FPL**	1,417	1,935	**$94,318**	475	$79,350	($179,614)	4,732	4,070	662	**$5,936**	$3,753,005	$11,486,562.70	**$4,901,660.98**
K) C and E combined [i.e., >$117 or >$36 per month and $25 premiums for those voer 150% FPL currently with $0 premium]	3,195	550	2,645. **NOTE: 513 have income >150% of FPL**	2,619	3,169	**$94,318**	487	$90,725	($43,114)	3,498	3,008	490	**$5,936**	$2,863,675	$18,813,921.18	**$4,745,066.64**

A) As a proxy for "evidence of any FICA contributions," we were limited to using earned income as an indicator; therefore, anyone with reported earned income >$0 was considered to have shown evidence of FICA contributions. It should also be noted that eithefore, anyone with reported earned income >$0 was considered to have shown evidence of FICA contributions. It shoul administrative costs to MA as current MAPP participants migrate to other MA categories.

B) Based on the informal nature of much of the work done by current MAPP participants, it has been argued that self-reported wages in CARES may overestimate the participants' ability to show actual FICA deductions from their wages, as much of their earnings ed wages in CARES may overestimate the participants' ability to show actual FICA deductions from their wages, as muc will actually leave MAPP because they cannot produce evidence of FICA, even if they earn the requisite $296.67/month.

C) As an alternative to Options A and B, we chose to use the point at which employees are required to begin paying FICA. These amounts are $1,400/year or $117/month for an employed person, and $433/year or $36/month for people who are self-employed. It is CA. These amounts are $1,400/year or $117/month for an employed person, and $433/year or $36/month for people wh pay FICA, these figures are the most accurate estimate we have available. The fact remains that many people, even those above this limit, simply do not pay FICA and may be unwilling or unable to do so (e.g., an employer may refuse to do the necessary papebove this limit, simply do not pay FICA and may be unwilling or unable to do so (e.g., an employer may refuse to do the ne above regarding self-reported wages.

D) Approximately 12% of the Disenrollment Survey respondents disenrolled because they could no longer afford the premium, but given that many of these respondents were most likely paying very high premiums, the percentage leaving due to a $25 premium should b the premium, but given that many of these respondents were most likely paying very high premiums, the pe participation, from 57% to 18%, if premium liability reaches 5% of **family** income. With the current MAPP figures, $25 would be at least 5% of the **individual's** total income for only 4% of the participants, a figure which would be lower if spousal income was included. But the literature does go on to state that, "Other research shows that many families who participate in public coverage programs either cannot afford or do not pay premiums and enrollment fees on time, even when these amounts are relatively low."[1] Based on these findings, we have chosen a conservative figure of 5% of the remaining eligible participants who will leave the program solely because of the $25 minimum premium. In addition, we expect, based on the percentage of MAPP participants who leave MAPP and subsequently enroll in another Medicaid eligibility category, that 86% of the remaining individuals who were no longer eligible OR who left the program due to the premium, will re-enroll in Medicaid.

E) The following figures provide an indication of how many MAPP participants would be Medicaid eligible without the availability of MAPP: 64% of the MAPP participants had MA in the month prior to MAPP, 86% had Medicaid at some point prior to MAPP, and 94% availability of MAPP: 64% of the MAPP participants had MA in the month prior to MAPP, 86% had Medicaid at some people leaving MAPP under the new eligibility criteria will move into another Medicaid eligibility category; thereby, shifting their costs within Medicaid, as opposed to reducing or eliminating them. As such, we have chosen the middle figure of 86% re-enmg their costs within Medicaid, as opposed to reducing or eliminating them. As such, we have chosen the middle figure of 86 Medicaid ledger completely.

F) The figures in this column represent total MAPP expenditures ($43,536,150.29) for the period April 2003 through March 2004 divided by the total number of MAPP participants (7,334) with any eligibility during that time period. These figure are not Full Yeaiod April 2003 through March 2004 divided by the total number of MAPP participants (7,33**3RE** accounted for in the annual average spending per MAPP participant shown in this column.

[1] **Source**: "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations." Julie Hudman and Molly O'Malley. The Kaiser Commission on Medicaid and the Uninsured.

Attachment H: Questions for MAPP Plus Discussion - July 7, 2004

1. Since premiums cannot be used as match for FFP, does the state claim the FFP on the difference between the individual's costs and the premium payment? Is this calculation done on an individual or aggregate level?
2. What is the maximum income level that can be established for eligibility without getting a federal waiver? Is there an issue with removing the asset test?
3. Will earned and unearned income be treated the same? In other words, there will be no cap on unearned income?
4. Are the FEDS more likely to look favorably at a program that allows people once they enter to stay on the program as they earn higher levels of income (e.g. BadgerCare) than a program that allows people to access Medicaid for the first time at an income level above 250% of FPL.
5. Is there an issue with allowing employers or individuals to pay the premium?
6. If there idea is to create a budget neutral program – is it feasible to spread risk across the relatively small group of eligibles (i.e. adverse selection – historical problem with HIRSP).
7. With such a small number of participants, one adverse health incident (e.g. major surgery) could make the estimates on which premiums were established completely inaccurate. Would the difference between the actual costs in a year and the premiums collected be made up by participants in the following year (i.e. added to the premiums) or would the state bear the financial risk? Will the FEDS allow plan participants to pay more than 100% of their medical expenses?
8. Would it be possible to create a MAPP Plus benefit package limited to long-term care benefits? This benefit package could wrap around existing employer coverage or HIRSP (for those that are working and uninsurable).
9. Alternatively, could MAPP Plus include a requirement similar to BadgerCare that if employer based coverage is available – it must be taken up as a pre-requisite to MAPP coverage.
10. Would MAPP Plus be individual or family coverage?
11. Could MAPP Plus be implemented as a demonstration project limited to individuals with prior Medicaid eligibility? If so, how long would someone need to be on Medicaid before becoming eligible for MAPP Plus.
12. What administrative issues (eligibility determination, premium collection, actuarial analysis for setting premiums) need to be considered?
13. What are the crowd-out issues to be considered?

Attachment I: Chronic Illness and Disability Payment System (CDPS) Categories

Table 2

Chronic Illness and Disability Payment System Categories with Sample Diagnoses

Diagnostic Category	Sample Diagnoses
Cardiovascular	
Very High	Heart transplant status or complications
Medium	Congestive heart failure, cardiomyopathy, tricuspid and pulmonary valve disease
Low	Endocardial disease, myocardial infarction, angina, coronary atherosclerosis, dysrhythmias
Extra Low	Hypertension
Psychiatric	
High	Schizophrenia
Medium	Bipolar affective disorder
Low	Other depression, panic disorder, phobic disorder
Skeletal and Connective	
Medium	Chronic osteomyelitis, aseptic necrosis of bone
Low	Rheumatoid arthritis, osteomyelitis, systemic lupus, traumatic amputation of foot or leg
Very Low	Osteoporosis, musculoskeletal anomalies, thoracic and lumbar disc degeneration
Extra Low	Osteoarthrosis, skull fractures, other disc and vertebral disorders
Nervous System	
High	Quadriplegia, amyotrophic lateral sclerosis and other motor neuron disease
Medium	Paraplegia, muscular dystrophy, multiple sclerosis
Low	Epilepsy, Parkinson's disease, cerebral palsy, migraine, cerebral degeneration
Pulmonary	
Very High	Cystic fibrosis, lung transplant, tracheostomy status, respirator dependence
High	Respiratory arrest or failure, primary pulmonary hypertension, selected bacterial pneumonias
Medium	Other bacterial pneumonias, chronic obstructive asthma, adult respiratory distress syndrome
Low	Viral pneumonias, chronic bronchitis, asthma, COPD, emphysema
Gastrointestinal	
High	Peritonitis, hepatic coma, liver transplant
Medium	Regional enteritis and ulcerative colitis, chronic liver disease and cirrhosis, enterostomy
Low	Ulcer, hernia, GI hemorrhage, intestinal infectious disease, intestinal obstruction
Diabetes	
Type 1 High	Type 1 diabetes with renal manifestations or coma
Type 1 Medium	Type 1 diabetes without complications or with neurological or ophthalmic complications
Type 2 Medium	Type 2 or unspecified diabetes with complications, proliferative diabetic retinopathy
Type 2 Low	Type 2 or unspecified diabetes without complications
Skin	
High	Decubitus ulcer
Low	Other chronic ulcer of skin
Very Low	Cellulitis, burn, lupus erythematosus
Renal	
Very High	Chronic renal failure, kidney transplant status or complications
Medium	Acute renal failure, chronic nephritis, urinary incontinence, cystostomy or urinostomy
Low	Kidney infection, kidney stones, hematuria, urethral stricture, bladder disorders
Substance Abuse	
Low	Opioid, barbiturate, cocaine, amphetamine abuse or dependence, drug psychoses
Very Low	Alcohol abuse, dependence, or psychosis
Cancer	
High	Lung cancer, ovarian cancer, secondary malignant neoplasms, leukemia, multiple myeloma
Medium	Mouth, breast or brain cancer, malignant melanoma, radiation or chemotherapy
Low	Colon, cervical, or prostate cancer, carcinomas in situ
Developmental Disability	
Medium	Severe or profound mental retardation
Low	Mild or moderate mental retardation, Down's syndrome
Genital	
Extra Low	Uterine and pelvic inflammatory disease, endometriosis, hyperplasia of prostate

See footnotes at end of table.

Table 2—Continued

Chronic Illness and Disability Payment System Categories with Sample Diagnoses

Diagnostic Category	Sample Diagnoses
Metabolic	
High	Panhypopituitarism, pituitary dwarfism, non-HIV immunity deficiencies
Medium	Kwashiorkor, marasmus, and other malnutrition, parathyroid, and adrenal gland disorders
Very Low	Other pituitary disorders, gout
Pregnancy	
Incomplete	Normal pregnancy, complications of pregnancy
Complete	Normal delivery, multiple delivery, delivery with complications
Eye	
Low	Retinal detachment, choroidal disorders, vitreous hemorrhage
Very Low	Cataract, glaucoma, congenital eye anomaly, corneal ulcer
Cerebrovascular	
Low	Intracerebral hemorrhage, precerebral occlusion, hemiplegia, cerebrovascular accident
Infectious Disease	
AIDS, High	AIDS, pneumocystis pneumonia, cryptococcosis, Kaposi's sarcoma
Infectious, High	Staphylococcal or pseudomonas septicemia, cytomegaloviral disease
HIV, Medium	Asymptomatic HIV infection
Infectious, Medium	Other septicemia, pulmonary or disseminated candida, toxoplasmosis, typhus
Infectious, Low	Poliomyelitis, oral candida, herpes zoster, parasitic intestinal infections
Hematological	
Extra High	Congenital factor VIII and factor IX coagulation defects (hemophilia)
Very High	Hemoglobin-S sickle-cell disease
Medium	Other hereditary hemolytic anemias, aplastic anemia, splenomegaly, agranulocytosis
Low	Other white blood cell disorders, purpura, other coagulation defects

NOTES: COPD is chronic obstructive pulmonary disease. GI is gastrointestinal. HIV is human immunodeficiency virus. AIDS is acquired immunodeficiency syndrome. CDPS is Chronic Illness and Disability Payment System. CDPS also includes categories for infants and a more detailed categorization for pregnancy. A complete description of CDPS diagnostic categories by ICD-9-CM codes is available at http://www.medicine.ucsd.edu/fpm/cdps/. ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification* (Public Health Service and Health Care Financing Administration, 1980).

SOURCE: Kronick, R., et al., San Diego, California, 2000.